

Welcome to our office

Michael F. Lett, M.D.

Today's Date \_\_\_\_\_

**PATIENT INFORMATION (Please Print)**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (circle): Male/Female

Mailing Address \_\_\_\_\_  
Street City, State Zip

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
Circle your primary number

Parents/Guardians (if minor) \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Email address \_\_\_\_\_ Primary Language \_\_\_\_\_

Marital Status (circle) Married Single Widowed Divorced Separated Spouse's name \_\_\_\_\_

Race (circle) Asian Black/African American Hispanic White Other (\_\_\_\_\_)

Employment (circle): Occupation \_\_\_\_\_ Employed / Unemployed / Retired / Disabled / Student

Employer/School Name \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_

**PRIMARY CARE PHYSICIAN** \_\_\_\_\_ Referred by \_\_\_\_\_

Pharmacy Name/Location \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION**

**MEDICAL**  
Insurance Carrier \_\_\_\_\_

**VISION**  
Insurance Carrier \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

**INSURANCE POLICYHOLDER and/or RESPONSIBLE PARTY: (If other than the patient)**

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Responsible Party SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer Name \_\_\_\_\_

**PATIENT SIGNATURE** \_\_\_\_\_ **Date** \_\_\_\_\_

Parent/Guardian (if patient is a minor)



**Michael F. Lett, M.D.,P.C**  
**Financial Policies & Privacy Practices**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**FINANCIAL AGREEMENT** All payments and past due balances are due and payable at the time of service. Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. **I understand that it is my responsibility to pay any co-pay, deductible amount, co-insurance payment, or other balance not paid by my insurance.** The patient is expected to present the insurance card at each visit. We accept cash, check, VISA, Mastercard, or Discover.

**FINANCIAL ASSIGNMENT** I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the CMS, its agents, or other insurance carrier, any information needed to determine these benefits or the benefits payable for related services.

**REFERRALS & AUTHORIZATIONS** It is the responsibility of the patient to obtain all required referrals from the primary care physician. Authorizations will normally be obtained by the office staff, provided the necessary information is available.

**RETURNED CHECKS** Patients who have checks returned for insufficient funds will expressly authorize their bank account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. The use of the check is the patient's acknowledgement and acceptance of this policy and its terms and conditions. A charge of \$25 will be added to the account for each returned check. If the fee is not paid within 10 business days, the charge may be turned over to a collection agency and appropriate fees and interest will apply.

**GLASSES ORDERS** Glasses orders are filed with your insurance company the same day you order them. Cancellations after 24 hours, or returned glasses that are not defective, will result in a \$25 service fee.

**CONTACT LENS FITTING FEE** A contact lens fitting fee will be charged for new contact lens wearers or any current wearers who are refit with a new lens type. Most vision plans do not cover this fee.

**PRIVACY PRACTICES** I have been advised of the Privacy Practices for this office and authorize Michael F. Lett, M.D., P.C. to release all information necessary for my treatment, payment or health care operations. This includes the sharing of information with other physicians and/or pharmacies. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. Copies of the Privacy Practices are posted in the waiting area and are available upon request.

Other persons who may receive my information \_\_\_\_\_

I may be contacted by mail or phone \_\_\_\_ Yes \_\_\_\_ No

A message may be left for me \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ Not Applicable

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Parent/Guardian (if patient is a minor)