LAVENBURG MEDICAL GROUP
DelMar Surgical and Cosmetic Treatment Center

Patient Information

Legal name required for insurance purposes (Please print)

Name: (first / middle / last) _____

Date of Birth: _____SS#_____ Gender as reported to your insurance carrier: M / F *(circle one)*

Race: (circle one) American Indian / Alaskan Native / Asian / African American / Pacific Islander / White / Latin American /

Ethnicity: (circle one) Latino / Not Latino / African American / American / Native American / Chinese / European

American / Preferred Language: (circle or add) English / _____

Will you need any visual aide, interpreter, or a mobility assistance during at your visit:_____

_____

Address: _____City/State: _____

Zip: _____County: _____

Cell #: ( ) _____Email: _____

Home #: ( ) _____ Work #: ( ) _____

Employer: _____Occupation: _____

PCP/Family Doctor: _____Office #: _____

Responsible Party / Guarantor

Name: (first / middle / last) _____Date of Birth: _____

Address: _____City/State: _____Zip: _____

Phone #: ( ) _____Email: _____

Relation to patient: _____Preferred contact method: _____

Emergency Contact (for minor child may be used for other parent)

Name: (first / middle / last) _____Relation to patient: _____

Cell #: ( ) _____Phone # : ( ) _____

Insurance Information (please provide current insurance cards)

- Primary Ins. Co.: _____ID: _____
- Policy Holder Name: _____Birthdate: _____
- Secondary Ins. Co.: _____ ID _____
- Policy Holder name: _____Birthdate: _____

Patient / Legal guardian signature: _____ **Date:** _____

Printed Name: _____

Douglas J, Lavenburg, M.D., P.A. | DelMar Surgical Center, L.L.C.

Douglas J. Lavenburg, MD
Kimberly R. Bristow, OD
Meredith A. Weinberger, OD
David G. Jupiter, OD FAAO

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One Centurion Dr. Suite 114, Newark, DE 19713
5305 Limestone Rd., Suite 201, Wilmington, DE 19808
302.993.0722 | 302.993.0931 | 410.392.6133

Financial Agreement

Thank you for choosing Douglas J. Lavenburg, M.D., P.A., and the Delmar Surgical Center, LLC for your family eye and skin care needs. We are pleased to welcome you to our practice. Our chief concern is that you and your family receive the finest care for maintaining healthy vision.

We understand that occasionally some of our patients will experience financial difficulties. It is our hope that you will bring these situations to the attention of our billing department or office manager to allow us to help you manage your account in the most effective manner. Please be advised that your insurance company is a contract with you and your employer, not our practice. We will be glad to submit your claims for payment, however, the final responsibility for payment due for services rendered is the sole liability of you, the patient, or the guarantor.

Our financial policy is as follows. Please feel free to discuss this with our billing department at any time. Please complete all insurance information, read our financial policy, and sign below to verify the receipt of this information.

1. We accept cash, check, American Express, MasterCard, Visa, Discover, Wells Fargo, and Care Credit.
2. **Medicare and some other insurance carriers do not pay for your refraction (checking your vision for glasses and/or contact lenses) when performed with your exam. A fee of $45.00 is due at the time of your visit. A refraction only exam is $55.00.**
3. If Medicare is your primary insurance, and your visit is for a medical condition, we will gladly submit your insurance claim to Medicare for you. You will be responsible for any co-insurance and/or deductible.
4. Your co-payment and self-payment amounts are due at the time of service.
5. You are financially responsible for all payments not paid by your insurance company.
6. If we do not participate with your insurance carrier, payment is due at the time of service.
7. If your insurance carrier requires a referral from your primary care provider for treatment, it is your responsibility to obtain the referral prior to your appointment. If you do not obtain and provide the referral within the time allowed by your insurance carrier, you will be financially responsible for services rendered.
8. **Returned checks are subject to a $25.00 service charge.**
9. **Any cancellation of product will incur a 20% fee.**
10. It is your responsibility to advise our office if you are being seen as part of a Vision Benefit Package provided by your employer prior to your appointment.
11. We are happy to provide any counseling on our billing practices, however, if your account is not paid within 60 days you will be responsible for payment plus a monthly finance charge of 1.5% per month.
12. If we are participating with your insurance company, we are contracted to adjust your account by a certain amount which is known as a "contractual write-off". This does not mean you will not have a balance. We will bill you for monies as directed by your insurance company.
13. If your account goes into "collections," in addition to your outstanding balance, you will be responsible to pay all collection fees associated with the collection agency as well as any legal or court costs as specified by our collection agency.
14. Any Medical Necessity forms/letters required by your insurance company, or any communication outside the usual and customary forms required for billing or communication with other physician providers, will be subject to a $25.00 administrative fee (including MVA forms).
15. We will be happy to complete your disability forms which are subject to a $25.00 administrative fee.
16. As a courtesy to our patients relocating out of the area, we will be happy to supply your new eye care provider a copy of your medical records at no charge. Any other requests for copies of medical records will be subject to a $25.00 administrative fee.
17. You will have 90 days from date of exam to return for a recheck of your glass's prescription for a fee of $35.00. There will be a courtesy waiver of this fee for glasses purchased at our optical locations. After 90 days, a $55.00 refraction fee will be charged.
18. *We require a 24 hour notice of cancellation of your appointment. Anything other will be subject to a $35.00 missed appointment fee.*

X_____

PATIENT, GUARANTOR OR PERSONAL REPRESENTATIVE'S SIGNATURE ***DATE***

Your signature on this page signifies that you acknowledge and accept the above information. This also serves as an assignment of insurance benefits to be paid directly to Douglas J. Lavenburg, M.D., P.A. and/or Delmar Surgical Center, LLC and/or Associates in Eye Care.

Revised 12/01/19

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Contact Lenses

The major use of contact lenses is for the correction of refractive errors. A small number of patients who meet pre-fitting criteria are unable to tolerate contact lenses regardless of fitting technique or lens type. It is important to remember that contact lenses are medical devices used to correct vision, and when used improperly, can cause permanent visual loss, especially when sleeping in them. Complications may arise with the use of contact lenses; the changes usually occur to the cornea and eyelids. Even a patient that has tolerated contacts for years may develop problems. For these reasons, yearly eye examinations are essential.

We also require all new contact lens patients, or patients new to our practice, to have a contact lens fit and evaluation, which includes a one week follow-up visit. If follow-up visits are not kept, we will not be able to order lenses or release the contact lens prescription.

Additionally, contact lens fitting and/or evaluations may not be covered by your insurance and payment in full is due at the time of service and is non-refundable.

Financial Responsibility for Contact Lens Services

New Contact Lens Wearers:

The glasses prescription is **not** the same as the contact lens prescription. All new contact lens wearers need to schedule a contact lens fit. The price typically ranges from $90 (single vision) to $160 for more complicated fits (soft bifocal / multivision). This fitting fee is non-refundable. The fit includes an initial evaluation, a contact lens training session, and a one week contact lens evaluation (follow-up). We provide a 30 day warranty on our services pertaining to the proper fitting of contact lenses. If the contact lens evaluation (follow-up) is not completed within 30 days, an additional charge of $35.00 will be incurred.

Established Contact Lens Wearers:

If a change in fit or lens type is required, a contact lens refit evaluation will be performed. The price typically ranges from $90 and up for single vision and up to $140 for bifocal refits. This refit service includes the contact lens refit evaluation and a one week contact lens evaluation (follow-up) with the newer lenses.

However, if the current lenses are satisfactory with the patient and the doctor, only a contact lens evaluation fee of $75-$85 will be charged to existing patients wearing standard lenses. New patients to our practice will be charged $85.00. A multifocal contact lens evaluation will be $85.

Contact Lens Ordering and Reordering Policy:

It is recommended that all patients being fit/refit for contacts purchase their first order from the practice.
Payment in full is required for all contact lens orders.
A fee of $20 is applied to all canceled and returned orders, as well as a 20% restocking fee.
In the event that it is necessary to return or exchange contact lenses, unopened and boxes not written on may be returned within 30 days.

I have read, understand, and agree with the Informed Consent and Financial Responsibilities for contact lens services.

Please sign below or, indicate "N/A" (Not Applicable) on the signature line if contact lens services are not being received.

✔
Patient, Guarantor or Personal Representative's Signature Date

Revised 10/08/19

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ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the practices Notice of Privacy Practices effective September 20, 2013.

Name (please print): _____
Signature: _____
Date: _____

I choose to ☐ Opt-In ☐ Opt-Out of receiving electronic text messages and/or emails from the practice regarding appointments and/or practice promotions.

I am a parent or legal guardian of _____ (patient name). I have received a copy of the practices Notice of Privacy Practices effective September 20, 2013.

I choose to ☐ Opt-In ☐ Opt-Out of receiving electronic text messages and/or emails from the practice regarding appointments and/or practice promotions.

Signature: _____
Date: _____

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective September 20, 2013 given to individual on _____ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _____

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation: _____ ☐ Telephone contact: _____
☐ Mailing: _____ ☐ Email:
_____
☐ Other: _____ Outcome: _____

Staff Name (please print): _____ Title: _____

Signature: _____ Date: _____