



Bayne Optical

Dr. Michael Lowe
16841 Kercheval Pl.
Grosse Pointe, MI 48230
(313) 885-5400

Today's Date _____

Patient Information

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip _____

Email _____

Call me on my: Work Phone: _____

(Please list all Home Phone: _____
phone #'s) Cell Phone: _____

Date of Birth _____ Sex: M F

Marital Status: Single Married Other

Employed Retired Full Time Student Part Time Student

Occupation _____

Employer _____

Address _____

How did you hear about us?

- Previous patient of Dr. Lowe Church paper
- Internet Radio ad Yellow Pages
- Referred by: _____
- Other: _____

Emergency Contact Name _____

Phone Number _____

Notice of Privacy Practices Acknowledgement of Receipt

I have received this office's notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice on request.

Signature _____

Relationship to patient _____

Billing and Insurance Information

Person responsible for payment _____

Relationship to Patient _____

SS # _____

Primary Vision Insurance Co. _____

Subscriber Name _____

Date of Birth _____

SS # / ID# _____

Secondary Vision Insurance Co. _____

Subscriber Name _____

Date of Birth _____

SS # / ID# _____

Primary Medical Insurance Co. _____

Subscriber Name _____

Date of Birth _____

SS # / ID# _____

Secondary Medical Insurance Co. _____

Subscriber Name _____

Date of Birth _____

SS # / ID# _____

Assignment and Release

I, the undersigned, assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

Disclaimer

As a courtesy to our patients, we are pleased to accept insurance assignment. However, it must be clearly understood that the "contract" is between you, the patient, and your insurance company. You are thereby responsible for your account and any amount not paid by your insurance company.

Contact Lens Fittings

All follow up visits required to finalize your contact lens prescription are included in your contact lens fitting fee. You are required to make and keep any follow up appointments necessary to finalize your prescription. If you fail to schedule or show up for your follow up appointments, then after 30 days you may be charged for your appointments. Appointments for medical eye problems, such as an infection, are not included in the contact lens fitting fee and will be charged separately.