Liberty Ophthalmology

27 Clairedan Drive
Powell, OH 43065
614-841-9300

Date_____ PATIENT INFORMATION

Patient's Last Name_____

First Name _____ MI_____

Nickname _____

Birthdate_____ Sex □ M □ F

Address _____

City_____

State_____ Zip_____

Primary Phone_____

□ OK to leave message with detailed information?

Secondary Phone_____

□ OK to leave message with detailed information?

Email_____

□ Married □ Widowed □ Single □ Minor

□ Separated □ Divorced □ Partnered

Occupation_____

Employer/School _____

Spouse/Parent/Guardian _____

IF DIFFERENT FROM ABOVE:

Insurance Subscriber _____

Birthdate _____

SSN_____

Address _____

City _____

State_____ Zip_____

IN CASE OF EMERGENCY, CONTACT:

Name_____

Relationship_____

Phone_____

Referred by _____

For office use only

Insurance _____

Co-Pay _____

Date _____

ALLERIES _____

Send report to:

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Office Notes

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Reviewed _____Reviewed _____ Reviewed _____

ACKNOWLEDGEMENT

1. I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Eric W. Lothes, MD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Eric W. Lothes, MD may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed and all claims have been submitted and paid.

   Signature_____ Date_____

2. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

   Signature_____ Date_____

3. I have received the Notice of Financial Policies and I have been provided an opportunity to review it.

   Signature_____ Date_____