

Patient Registration

Who will you be seeing today?

Please check appropriate box(es).

- Korrekt Optical
- Spencer Maudlin, O.D.
- Seth Summers, O.D.

Date _____

Store _____

Name _____

Address _____

City/State/Zip _____

Home Phone # _____ Work Phone# _____

Social Security # _____ Male/Female _____

Date of Birth _____ Marital Status: M/S/W/D/ _____

Name of Spouse _____ Spouse D.O.B. _____

Spouse Employment _____ Spouse Social Sec.# _____

Phone Number _____

Insurance Information

Primary Insurance Co.: _____

Supplemental Insurance Co.: _____

If you are unable to keep your appointment, please cancel 24hrs. in advance or a \$20 charge will be applied.

Korrek Optical

4036 Dutchmans Lane, Louisville, KY 40207
4747 Dixie Highway, Louisville, KY 40216
1404 Eastern Boulevard, Clarksville, IN 47129

Spencer Maudlin, O.D.
Seth Summers, O.D.

I authorize treatment, of the previously mentioned person, on the patient registration form. I have read the following “insurance claim filing” information and agree to pay all fees for such treatment if denied by my insurance carrier.

INSURANCE CLAIM FILING

Medicare – We will file all service to your insurance carrier (s). You will be responsible for any deductible, so-payment or non-covered services. We are A Medicare Provider.

All Other Insurances – We will file all services not covered by your Carrier(s), as a courtesy to you. You will be responsible for any services not covered by your carrier that would not otherwise be adjusted due to any contract we may hold with your insurance carrier. Your responsibility may include, but will not be limited to, copay, deductible or charge derived due to exclusion (s) in your policy, such as routine eye exam coverage, or lack of a referral number if your policy requires one.

I authorize the release of any medical information necessary to process my insurance claim, and I authorize payment of medical benefits to one of the above listed physicians or supplier for services or medical equipment supplied. I also understand that I will be responsible for and promise to pay all deducted and co-insurance amounts not covered by Medicare, Medigap or my Private Insurance.

Date

Signature of Responsible Party