MICHAEL E. LUTZ, M.D.

Patient Registration

Name _____Marital Status _____Occupation _____

Street/Billing Address_____

City _____ State _____ Zip code _____ E-Mail _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

Date of Birth _____ Age: _____ Sex: _____ SSN: _____

Employer _____ Address_____

Pharmacy Name: _____ Phone Number: _____

Referred by_____ Primary Care Provider_____ Phone _____

Primary Insurance: _____ ID# _____

Name of policy holder _____ DOB _____ Relationship to patient _____
(If other than patient)

Secondary Insurance: _____ ID# _____

Name of policy holder: _____ DOB _____ Relationship to patient _____
(If other then patient)

Payment is due at time of service for co-pays, deductibles and any services not reimbursed by insurance. We accept Cash, Checks, Visa, MasterCard, and Discover. Payment plans are not available. Secondary insurance will be filed one time. If payment is denied, you will be requested to pay the balance. Accounts with patient balances after insurance determination are due in full within 30 days of statement. Unpaid accounts will be turned over to a collection agency.

Regarding medical information communication: do we have permission to
Leave a message on your answering machine at: home _____ work _____ cell _____
Discuss your medical condition with _____
Spouse ____ Parent ____ Child ____ Other _____

This office has provided its notice of privacy practices for me to review. My signature authorizes this office to release, as well as request, information for treatment, payment and health care operations, and certifies that I have read and understand the financial policies outlined above.
I understand that by signing this registration form I am fully responsible for my account, not insurance.

Signature _____ Date: _____

PLEASE PRESENT PHOTO ID AND INSURANCE CARDS TO RECEPTIONIST

Reviewed: _____ Reviewed: _____ Reviewed: _____ Reviewed: _____ 12/17