Lentz Pediatrics

10777 Hwy 412 West
Lexington, TN 38351
Phone 731-968-5558
Fax 731-968-5567

19 Security Drive
Jackson, TN 38305
Phone 731-664-9040
Fax 731-664-9041

Jonathan D. Lentz M.D.

(Please print clearly)

Patient's Full Name: _____ Age: _____

Race: African American White Hispanic Other (please circle one)

Date of Birth: _____ Social Security No: _____ Sex: ❑ M ❑ F

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

May Lentz Pediatrics Text You for Appointment Reminders: ❑ Yes ❑ No

If Yes, Phone Number: _____

RESPONSIBLE PARTY INFORMATION:

Mother Name: _____ Social Security No: _____

Employer: _____ Phone No: _____

Date of Birth: _____ Address: _____

Father Name: _____ Social Security No: _____

Employer: _____ Phone No: _____

Date of Birth: _____ Address: _____

In case of emergency contact (other than parent): _____

Address: _____ City: _____ State: ____ Zip: _____

Relationship: _____ Phone No: _____

INSURANCE INFORMATION:

Primary Coverage, Name of Carrier: _____

Policy ID No: _____ Group No: _____

Policy Holder Name: _____

Policy Holder DOB: _____

Secondary Coverage, Name of Carrier: _____

Policy ID No: _____ Group No: _____

****ALL CO-PAYS AND DEDUCTIBLES ARE DUE WHEN SERVICES ARE RENDERED****

TREATMENT AUTHORIZATION:

I HEREBY AUTHORIZE Lentz Pediatrics and its associates to undertake medical treatment, Diagnostic testing as deemed medically necessary.

PAYMENT AUTHORIZATION:

I, _____ hereby authorize Jonathan Lentz, M.D. to furnish information concerning services rendered. I direct the insurer to pay, without equivocation, directly to the physician, all the benefits due him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photo static copy of this authorization will be valid as the original.

*Obtaining referral information is the patient's responsibility.

In the event my account should become delinquent, I will be responsible for all the collection fees. These fees will include a 30% service charge and any legal fees incurred through the collection process. All payments due because of patient's failure to cancel appointment will be billed direct to the patient for payment. Reimbursement from insurance will be the patient's responsibility.

Lentz Pediatrics is happy to serve patients that do not have insurance and/or patients that are self-pay. It should be noted that deposits are required for the services listed below on the day that the service is rendered.

Procedure	**Deposit Required**
Office Visit-Established Patient	$50.00
Office Visit- New Patient	$100.00

I understand as a self-pay patient, I am responsible for the above listed deposit amounts for services provided by Lentz Pediatrics on the day the services are delivered. I will be billed for the remaining amount of the cost of the service.

Signature of Patient or Guardian_____ **Date**_____