Lock Family Eye Care, LLC
101 Jordan Creek Parkway, Suite 12190
West Des Moines, Iowa 50266
(515)267.1312 Fax (515)267.9129

Insurance Acknowledgement

I give permission for Lock Family Eye Care and Drs. Lock to file the professional services performed at Lock Family Eye Care to the insurance company stated below. I acknowledge that my insurance will most likely not cover the contact lens fitting fees; therefore, it will be collected on the day of service. In addition, I am responsible for the copay, coinsurance, and/or meeting my deductible on my insurance policy. If my insurance company does not pay for the professional services received, I am responsible for the balance due on my account. This includes procedures that are covered but have been applied to the deductible. Please note that this form is not a guarantee of payment.

Fill this only please

Insurance Company: _____ Policy Number: _____

Secondary Insurance (if applicable): _____ Policy Number: _____

Print Patient's name: _____ ☐F ☐M DOB: ___/___/___ SSN: _____

Patient/Parent Signature: _____ Date: ___/___/_____

Patient's Address: _____ City: _____ State: _____ Zipcode: _____

Home Phone Number: _____ E-Mail: _____

Please fill out information if the policy holder is not the patient

Policy Holder: _____ ☐F ☐M DOB: ___/___/___ SSN _____

Relationship to Patient: ☐ Spouse ☐Parent

Office Use

CPT code

92002 92004 92012 92014 S0620 S0621
99202 99212 99203 99213 99204 99214

Contact Lens Fitting:
92310

Refraction
92015

Visual Field
92081 92082 92083

Photos
S9986 92250 ICD-9_____

Other CPT code: _____

ICD-9_____

Exam Total Charges:_____

CL Fit:_____

Copay:_____

Optomap Fee:_____

Total paid DOS:_____

Date Submitted:_____

Insurance paid:_____

Balance Due:_____

Reimbursed amt/date:_____
Billed Date:_____
Paid Date:_____