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San Diego, CA 92103  
619-295-4194

Mr.    Mrs.    Miss    Ms.    Dr.

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

S.S.# \_\_\_\_\_ D.L.# \_\_\_\_\_

Home Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Vision Plan: \_\_\_\_\_ Vision Plan Subscriber ID# \_\_\_\_\_

Medical Plan: \_\_\_\_\_ Physician: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

Who may we thank for referring you to our office: \_\_\_\_\_

**PAYMENTS & CO-PAYMENTS:**

All required payments, co-payments, deductibles, and other out-of-pocket expenses are due in full at the time services are rendered or materials are provided, unless other specific financial arrangements have been made prior to your scheduled appointment. The office accepts American Express, VISA, MasterCard, Debit Cards that display the VISA or MasterCard logo, and personal checks with proper identification. All personal checks returned for any reason will be subject to a \$25 service charge without exception.

**VISION PLAN COVERAGE & INSURANCE BENEFITS:**

It is your responsibility to understand the nature of your vision plan and insurance benefits prior to your scheduled appointment. The employees of INVISION EYE CARE OPTOMETRY will, to the best of their knowledge and understanding, help answer any questions you may have regarding your vision plan coverage or insurance benefits; however, no guarantee of accuracy regarding eligibility, coverage, or benefit information can be made by anyone other than your vision plan or insurance carrier directly.

**ASSIGNMENT OF BENEFITS:**

I hereby authorize assignment of vision plan and insurance benefits to INVISION EYE CARE OPTOMETRY for the purpose of determining eligibility, benefits, billing, and collecting for all services rendered and materials provided. In addition, I authorize INVISION EYE CARE OPTOMETRY and any of its employees to furnish information concerning my present condition to insurance companies and referring doctors as deemed necessary.

**MISSED, BROKEN, & CANCELLED APPOINTMENTS:**

If a scheduled appointment time is missed, broken, or cancelled for any reason without 24 hours notice, a fee of \$50.00 may be assessed to your account. Please notify the office at least 24 hours in advance if you are unable to keep your appointment.

**HIPAA COMPLIANCY:**

I acknowledge that I have received a copy of the Notice of Privacy Practices (HIPAA) for this office. I have read and understand the terms and conditions outlined above, and I hereby certify that all of the information provided is true and accurate to the best of my knowledge and understanding.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*(Parent or Guardian to sign if minor)*

**OFFICE USE ONLY:**

Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_