Drs. Kline and Boyd

OPTOMETRISTS, PLLC

Focusing on clear, healthy vision for the whole family

Welcome to the office of Drs. Kline, Boyd and Chivers.

We provide complete eye health examinations, contact lens fittings/evaluations, pediatric examinations, lasik co-management, dry eye syndrome therapy, red eyes, and diabetic retinopathy.

Please fill in the following information

Patient Name:_____ **Appointment Date:**_____

Vision Insurance:_____
ID#_____

Member Name:_____
Relationship to Patient:_____

Medical Insurance:_____
ID#_____ **Group#**_____

Member Name:_____
Relationship to Patient:_____

- **Your insurance is a contract between you and your insurance company.** You are ultimately responsible for payment regardless of your insurance's arbitrary determination of usual and customary fees.
- **A 50% deposit is required for all eyeglass and contact lens orders.** If your insurance company *does* cover hardware, our billing department will forward charges for you. However, you are responsible for any non-covered items and any difference in fees above and beyond your insurance companies allowable amount.
- **All eyeglass lenses are custom made.** Cancelled orders will be subject to a 30% cancellation/restocking fee.
- **Insurance referrals for medical visits are your responsibility.** All referrals must be obtained prior to your appointment unless a medical diagnosis has yet to be determined. If referrals are not received in a timely manor after your initial visit you are responsible for all charges.
- **Insurance claims can not be backdated.** All services and orders are billed on the appointment date.
- **Knowledge of benefits and eligibility is your responsibility.** All insurance plans are unique, our staff may not have the information specific to your plan available to them before your visit.
- **All co-pays are due at the time of service.** If *not* paid, a $10.00 service fee will be applied to your account.
- **Refractions are considered routine.** A refraction is the part of the exam where the doctor determines your prescription. This service may *not* be covered by your insurance, if you do not have routine coverage this charge is your responsibility.

By signing below I authorize the following:

-This form to serve as a Lifetime Signature on File.

-Payment from my insurance company for services rendered to be made payable to the doctors in this office. Any overage in payment received by the office from the insurance will be refunded to me.

-I have read and/or understood the Notice of Privacy Practices and I further consent to the release of my health information for purposes of treatment, payment and health care operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices.

Please list to whom you would like your eye health records released to:_____

Patient Signature:_____ **Date:**_____
(Parent or Guardian)

*If you are signing as a personal representative of the patient, parent or guardian please describe your relationship. We ask that an adult please accompany all children to their appointments.

Roy A. Kline, OD ~ Carolee R. Boyd, OD ~ Dawn S. Chivers, OD
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