Drs. Kline and Boyd

OPTOMETRISTS, PLLC

Focusing on clear, healthy vision for the whole family

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

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:_____ | **Medical Insurance:**_____

ID#_____ | **ID#**_____ **Group#**_____

Member Name:_____ | **Member Name:**_____

Relationship to Patient:_____ | **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.
- **PAYMENT-IN-FULL is required for all eyeglass and contact lens orders.** You are responsible for any non-covered items and any fees above and beyond your insurance company's allowable amount.
- **All eyeglass lenses are custom made.** Cancelled/Returned orders will be subject to a **50% lab/return fee**. In the instance a Vision Plan is billed- *NO* refunds will be given on copays collected for returned items.
- **Insurance referrals required for medical visits are your responsibility.** All referrals must be obtained prior to your appointment. You are responsible for all charges if referrals are not received in a timely manner.
- **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.
- **A 24hr Notice is required for canceled appointments.** Failure to do so may result in a $25 "NO-Show" fee.
- **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 so, this charge is your responsibility.
- **An Adult is required to accompany all children to their appointments.** The adult accompanying the minor is responsible for payment of services regardless of the relationship or financial arrangement.

By signing below I authorize:

-This form to serve as a Signature on File for my account.

-Payment from my insurance company for services rendered to be made payable to the doctors in this office and acknowledge that any payment overages received from 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.

-Permission to retrieve my prescription medication history from my Pharmacy:_____
(Pharmacy Name)

-The release of my eye health records to:_____ _____
(Family Members/Friends) (Location)

***Are you experiencing any flu-like**(fever, congestion, cough, nausea, aches, sore throat) **symptoms today Y / N**

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

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