



First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Phone #: _____

Email Address: _____

Address: _____

City: _____ State: _____ ZIP: _____

I authorize the following methods to be contacted and/or notified of any updates to my orders or any appointments I may have in the future (check all that apply):

☐ Text ☐ Email ☐ Phone Call

DILATION

The dilation of the pupils is the only way to have a thorough and complete eye exam. It allows your optometrist to obtain a better view inside your eyes to ensure optimal eye health. For this reason, **it is required by law of this State to be a part of all first-time routine exams.**

☐ I wish to have a complete eye exam including dilation

☐ I wish to have a complete exam but would like to reschedule the dilation. **I understand that there may be diseases, defects, lesions or other problems that were not examined or ruled out today; and as a result, I do not hold Kandace Haines, O.D., Ocean Optics of Delray Beach, Inc. or its associates liable for any delay in diagnosis and treatment that may have resulted from my deferring dilation today. I understand that it is my responsibility to reschedule this portion of the exam.**

PATIENT INITIALS _____

REFRACTION

If you want to know if a new pair of glasses will improve your vision, then a test called a REFRACTION must be done. **Under Federal Law, we are REQUIRED to charge for this test.** *Please note that some **vision plans** MAY include a refraction.* Our office staff will let you know if this fee applies to your visit. **I understand that the REFRACTION is a NON-COVERED service and that I am responsible for the payment of the fee AT THE TIME OF SERVICE, if applicable.** ☐

PATIENT INITIALS _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Kandace Haines, O.D and Ocean Optics, Inc all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am responsible for all co-payments and/or co-insurance.** I also understand that if my insurance does not remit payment, I am responsible for any charges incurred. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I, hereby, authorize the doctor to release all information necessary to secure the payment of benefits and authorize the use of my signature of all insurance submissions.

Signature: _____

Date: _____ Relationship: _____