

## PATIENT INFORMATION

DATE: \_\_\_\_\_

|                   |                  |  |               |
|-------------------|------------------|--|---------------|
| Name:             |                  |  | Gender: M / F |
| Date of Birth:    | Age:             | Single / Married / Partnered / Widowed |               |
| Mailing Address:  | City:            | State:                                 | Zip Code:     |
| Street Address:   | City:            | State:                                 | Zip Code:     |
| Daytime Phone:    | Alternate Phone: |  | Work / Cell   |
| Social Security#: | Email Address:   |  |               |

If the patient is a minor, the following must be completed:

|                                       |               |               |
|---------------------------------------|---------------|---------------|
| Responsible Party:                    | Relationship: | Soc Security: |
| Address (if different from patient's) |               |               |

All patients and / or responsible parties please complete the following:

|   |             |                 |                  |
|---|-------------|-----------------|------------------|
| Employer:                                     | Occupation: | Business Phone: |                  |
| Business Address:                             |             |                 |                  |
| Name of Insurance Plan:                       |             | Physician:      |                  |
| Insurance Subscriber's Name:                  |             | DOB:            | Social Security# |
| Other Insurance Plan:                         |             |                 |                  |
| Insurance Subscriber's Name:                  |             | DOB:            | Social Security# |
| Subscriber's ID#:                             |             | Employer:       |                  |
| In case of emergency, who should be notified? |             | Phone Number:   |                  |

### ASSIGNMENT AND RELEASE

I request that payment of authorized insurance benefits for any services furnished me, be made on my behalf to Lynette M. Kline, O.D. I hereby assign directly to Lynette M. Kline, O.D., all medical benefits, if any, otherwise payable to me for services rendered. (Note: payment is expected at time of service.)

I authorize any holder of medical information about me to release all information necessary to determine and secure payment of benefits.

I authorize the use of this signature on all my insurance submissions.

I understand that I am ultimately responsible for all charges whether or not paid by insurance.

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

### PLEASE COMPLETE IF PATIENT IS UNDER 18

In case of my absence, I hereby give permission to Lynette M. Kline, O.D. and Lisa Harvey, O.D., FCOVD for treatment as they deem necessary to my child.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

### ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

I acknowledge that I have viewed/received a copy of the Notice of Privacy Practices for Lynette Kline, O.D. and Lisa Harvey, O.D., FCOVD.

Print Name: \_\_\_\_\_

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

Note: You may refuse to acknowledge receipt of this Notice of Privacy Practice. If you do, we cannot refuse service to you.

Patient refused to acknowledge receipt of this Notice of Privacy Practice. Employee Initial: \_\_\_\_\_ Date: \_\_\_\_\_