Takahashi Eye Care
Joyce Takahashi, O.D.
Michael Pack, O.D.

Welcome to our office!

Mr./Ms./Mrs./Miss/Dr._____ Date_____
Address_____
City_____ State_____ Zip Code_____
Home Phone_____ Work_____ Cell_____
Social Security No._____ D.OB. _____
Email address_____@_____
Referred by? _____
Who is your general physician (family doctor)? _____
Occupation/ Employer: _____
Person responsible for this account_____
Home Phone_____ Work_____
Vision Insurance_____ Subscriber Name_____
Insurance ID #_____ Subscriber D.O.B. _____
Relationship to Subscriber: Member Spouse Dependent Partner

The Optomap Retinal Screening

The Optomap Retinal Screening is standard of care in our practice for all patients. It is fast, painless, and does not require dilating eye drops. The Optomap Retinal Exam provides the doctor a view of approximately 82% of your retina in one panoramic image. It enhances detection of even the earliest signs of disease, both in your eyes and body. **THE SCREENING FEE IS $29.00**, and is **NOT** covered by most insurances. Please sign **THE ATTACHED PAGE** if you elect **TO DECLINETHIS TEST TODAY**.

Signed_____ Date_____

Authorization and Responsibility Agreement

Payment is expected at the time professional services are rendered. A 50% deposit is required before materials are ordered; balance is due upon delivery of materials.

I have requested Takahashi Eye Care, PC to bill my insurance company for covered services on my behalf. I clearly understand that I am responsible for payment. I hereby authorize any insurance company to pay directly to Takahashi Eye Care, PC. A signature listed below can be considered as an original copy of my consent for insurance purposes.

Signed_____ Date_____

Privacy Policy

In the course of providing services to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, obtain payment for services and to conduct health care operation involving our office. Your signature below gives your consent for our office to use your health information to treat you and to obtain payment for our services and to perform health care operations. You have the right to request restrictions on how our office uses your information. You have the right to a copy of our *Notice of Privacy Practices.*

Signed_____ Date_____

Cancellation Policy

I understand that Takahashi Eye Care requires me to provide a minimum of 24 hour notice for any cancellations or scheduling changes, or a fee of $35.00 may be incurred.

Signed_____ Date_____