

**PATIENT INFORMATION**

Patient's Name (Last, First, Middle Initial) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Bus. Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email address \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Sex : Male / Female                      Marital Status : S   M   W   D

Family Doctor : \_\_\_\_\_

**Referred By** (please circle) Insurance/ Patient/ Physician/ Optometrist/ Other

Name \_\_\_\_\_ Insurance Co . \_\_\_\_\_

.....  
**Name of person responsible for the bill or holder of Insurance Policy  
(If different from Patient)**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Employer \_\_\_\_\_

Relationship of patient to Insured : Self   Spouse   Child   Other \_\_\_\_\_

.....  
**Please provide us with your Insurance Card so we may make a photocopy**

Name of **Primary** Insurance \_\_\_\_\_

Name of **Secondary** Insurance \_\_\_\_\_

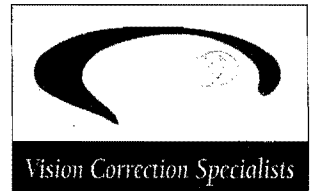
.....  
I request that payment of authorized benefits be made on my behalf to Richard S. Kalski, M.D., P.A. for any services furnished. I authorize Richard S. Kalski, M.D., Darrel J. Mase Jr. M.D., to release to my insurance company, its agents, or any other supplier of medical benefits, any information needed to determine those benefits, or the benefits payable for related services.

I understand that if I am seen without a referral from my primary care physician and my health plan requires that I obtain that referral, then my health plan may not cover the charges, costs, or expenses of my examination by Richard S. Kalski, MD., Darrel J. Mase, Jr. M.D. In that case, I will be responsible for paying my bill.

**REFRACTIONS:** (The procedure to check or determine your eyeglass prescription is not covered by Medicare and most insurance companies). There will be a \$35.00 charge to the patient for all refractions. Please notify the technician, if you do not wish to have a refraction.

\_\_\_\_\_  
Signature-Patient or Authorized party

\_\_\_\_\_  
Today's date



Vision Correction Specialists  
**Richard S. Kalski, M.D.**  
**Darrel J. Mase, Jr., M.D.**

7000 S.W. 97th Avenue, Suite 114

Miami, Florida 33173

T: 305.665.2023

F: 305.665.2363

www.kalskivision.com

kalskivision@aol.com

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

### SECTION A: Patient Giving Consent

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Telephone \_\_\_\_\_ Social Security \_\_\_\_\_

### SECTION B: To the Patient – Please read the following statements carefully

**Purpose of Consent.** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

**Notice of Privacy Practices.** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

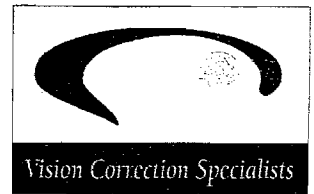
**Contact Person: Richard S. Kalski, M.D. & Darrel J. Mase, Jr., M.D.**  
**Address: 7000 S.W. 97 Avenue Suite 114, Miami, Florida 33173**  
**Telephone: (305) 665-2023**

**Right to Revoke.** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

### SIGNATURE

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

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



**Richard S. Kalski, M.D.**  
**Darrel J. Mase, Jr., M.D.**

7000 S.W. 97th Avenue, Suite 114

Miami, Florida 33173

T: 305.665.2023

F: 305.665.2363

[www.kalskivision.com](http://www.kalskivision.com)

[kalskivision@aol.com](mailto:kalskivision@aol.com)

### **IMPORTANT NOTICE TO MY PATIENTS**

Please be aware that your vision could be temporarily impaired following eye examinations at my office. Eye drops that dilate your pupils may be a necessary part of your exam to assure accurate results and to aid in the diagnosis and treatment of your eye disease. The use of dilating drops as well as other methods of examination and treatment may cause blurred vision, possibly interfering with your ability to drive safely. If your vision is blurred, please feel free to stay in my office until your vision returns to normal. If necessary, my staff can assist you in arranging for alternative transportation. If you have any questions, please ask my staff.

Patient Signature \_\_\_\_\_

Witness Signature \_\_\_\_\_

Date \_\_\_\_\_

### **NOTICE TO PARENTS AND LEGAL GUARDIANS**

I understand that my child's eyes may be dilated which could temporarily impair vision. Climbing, bike riding and other activities could be potentially dangerous and should be avoided until vision returns to normal. If you have any questions, please ask my staff.

Parent's Signature \_\_\_\_\_

Witness Signature \_\_\_\_\_

Date \_\_\_\_\_