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REDLANDS OPTOMETRY GROUP

APPOINTMENT CHECK IN FORM

Please fill form out completely

PLEASE PRINT

First Name: _____ Last Name: _____

Address: _____

Please fill in complete address (Street, City, and Zip Code)

Phone Number: _____ Cell Phone: _____

Subscriber Name (if different): _____

We are now making greater use of email to communicate with our patients. To help us provide the most prompt service possible, please enter your current email address below:

E-Mail Address: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I understand that if I have questions or complaints regarding my privacy right that I may contact the person listed on the sheet I received informing me of my rights. I further understand that the practice will offer me upgrades to this Notice of Privacy Practices should it be amended, modified or changed in any way.

Signature: _____

ASSIGNMENT AND RELEASE

I hereby authorize the physician to release any information required to process a claim. I also **authorize my insurance benefits to be paid directly to the physician** and **I understand I am financially responsible for non-covered services.** I have not used my insurance vision benefits elsewhere.

Signature: _____

Date: _____