Privacy Policy

This notice describes how medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

The Vision & Eye Medical Diagnostic Laser Center is committed to serving our patients with professionalism and care, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of taking care of our patient’s needs, it may become necessary to share information with other health providers. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire lab analysis
- During health care operations, we may require a second opinion

The Vision & Eye Medical Diagnostic Laser Center is committed to adhering to all Federal, State, and Local laws and regulations regarding Privacy Practices. If any uses or disclosures other than those listed above, information will only be released with the written authorization of the patient in question. This written authorization may be revoked at any time.

If you have any questions regarding this Privacy Policy, feel free to contact our office.

I have read and understand the above Privacy Policy.

Patient Signature ___________________________ Date ____________
R. CHARLES DUKE, O.D.
VISION & EYE MEDICAL DIAGNOSTIC LASER CENTER

PATIENT INFORMATION

Date

THANK YOU - For Allowing Us To Provide You With Your EYE MEDICAL CARE. As an OPTOMETRIC PHYSICIAN, I am dedicated to providing you with the latest in state of art EYE MEDICAL TESTING. Today, we will be doing Eye Medical Testing to ensure that you do not have any eye medical diseases, or to evaluate your current eye medical condition. If you have MEDICAL INSURANCE, these fees will be covered by your MEDICAL INSURANCE except for your Co-Pay or Deductible. Your MEDICAL INSURANCE recognizes that these eye medical tests or eye medical procedures should be done to meet the STANDARD OF EYE HEALTH CARE.

PATIENT’S NAME ____________________________  AGE ______  BIRTH DATE ______

Social Security Number# ____________________________  Drivers Licence Number # ______

MEDICAL INFORMATION

CITY

YOUR PHYSICIAN’S NAME ____________________________

Are you under a Medical Doctor’s Care at this time? □ NO □ YES WHY? ____________________________

Have you been hospitalized during the Past Two Years? □ NO □ YES WHY? ____________________________

Are you Presently taking any Medications, Pills and/or Drugs? □ NO □ YES WHY? ____________________________

Have you had any ALLERGIC REACTIONS to any MEDICATION or Drug? □ NO □ YES WHY? ____________________________

Do you smoke? □ NO □ YES How Much? ____________________________

Do you use Alcohol? □ NO □ YES How Much? ____________________________

(Women Only) Are you pregnant? □ NO □ YES How Many Months? ____________________________

Approximate date of last EYE MEDICAL EXAM? ____________________________

Eye Physician ____________________________

CHECK YOUR EYE - MEDICAL COMPLAINTS or REASON FOR AN OFFICE EYE-MEDICAL VISIT:

☐ Headaches ☐ Eye Redness ☐ Mucous Discharge ☐ Wandering Eye ☐ Syst
☐ Dizziness ☐ Eye Tearing ☐ Eye Infection (Red Eye) ☐ Night Blindness ☐ Fainting
☐ Eye Pain ☐ Eye Itching ☐ Flashes of Lights ☐ Tunnel Vision ☐ Check EYE HEALTH
☐ Halos ☐ Eye Burning ☐ New Floaters in the Eye ☐ Double Vision ☐ Check For CATARACTS
☐ Spots ☐ Eye Injury ☐ Sudden On-set of Blurring ☐ Loss of Side Vision ☐ Check For GLAUCOMA
☐ Bulging ☐ Crossed Eyes ☐ Vision That Comes & Goes ☐ Excessive Blinking ☐ Check For Macular Degeneration
☐ Allergies ☐ Eye Swelling ☐ Sinus Trouble with Eyes ☐ Hay Fever with Eyes ☐ NO OTHER Eye Complaints Are Present
☐ Crousting ☐ Twitching ☐ Sudden Loss of Vision ☐ Sensitivity to Light ☐ Other

MEDICAL REASONS FOR WANTING or NEEDING AN EYE MEDICAL OFFICE VISIT:

Need a Current Medical Eye Health Examination because: (1) Patient Medical Condition (2) Family Medical History (3) Last Eye Medical Exam over 1 Yr Ago

PLEASE MARK THE CORRECT BOXES BELOW:

(1) “P” Box = Patient’s Medical Condition  (2) “FM” Box = Family Medical History  (3) “LE” Box = Last Eye Medical Health Exam was over 1 yr Ago

Reason for Your Medical Visit:

P  FM  LE
Cataracts ☐ ☐ ☐ Kidney ☐ ☐ ☐
Glaucoma ☐ ☐ ☐ High Blood Pressure ☐ ☐ ☐
Diabetes ☐ ☐ ☐ Heart Trouble / Murmurs ☐ ☐ ☐
Blindness ☐ ☐ ☐ Hardening of the Arteries ☐ ☐ ☐
Arthritis ☐ ☐ ☐ Diabetic Retinopathy ☐ ☐ ☐
Anemia ☐ ☐ ☐ Hypertensive Retinopathy ☐ ☐ ☐
AIDS ☐ ☐ ☐ Glaucoma Suspect ☐ ☐ ☐
Hepatitis ☐ ☐ ☐ Cold Sores / Fever Blisters ☐ ☐ ☐
Nervousness ☐ ☐ ☐ Low Blood Pressure ☐ ☐ ☐
Hemophilia ☐ ☐ ☐ Chemotherapy / Radiation ☐ ☐ ☐
Chest Pain ☐ ☐ ☐ Stroke ☐ ☐ ☐
Emphysema ☐ ☐ ☐ Chemotherapy / Radiation ☐ ☐ ☐
Retina Tears / Detachments ☐ ☐ ☐
Chronic Iris / Uvetis ☐ ☐ ☐
Macular Degeneration ☐ ☐ ☐
Visual Field Defects ☐ ☐ ☐
Corneal Dystrophies / Ulcers ☐ ☐ ☐
Retinal Degeneration ☐ ☐ ☐
Shortness of Breath ☐ ☐ ☐
Parathyroid Disease ☐ ☐ ☐
Epilepsy or Seizures ☐ ☐ ☐
Heart Value / or Pacemaker ☐ ☐ ☐
Hypoglycemia ☐ ☐ ☐
NO OTHER Medical Complaints Are Present ☐ ☐ ☐

Is there any OTHER MEDICAL HISTORY INFORMATION, THAT YOU or A FAMILY MEMBER HAS HAD or HAS, THAT WE SHOULD KNOW ABOUT. □ NO □ YES

Signature ____________________________  Parent Signature ____________________________  Date _______ / _______ / _______
PATIENT INFORMATION

THANK YOU - For Allowing Us To Provide You With Your VISION & EYE MEDICAL CARE - Along with your Eye Wear. As an OPTOMETRIC PHYSICIAN, I am dedicated to providing you with the latest in state of art VISION & EYE MEDICAL TESTING. If you have VISION INSURANCE, it will cover basic fees, you are responsible for Co-Pays & Add-On Fees set by your VISION INSURANCE. Today, we will also be doing Eye Medical Testing to insure that you do not have any eye medical diseases. If you have MEDICAL INSURANCE these fees are covers except for your Co-Pay or Deductible. Your MEDICAL INSURANCE recognizes that these eye medical tests or eye medical procedures should be done to meet the STANDARD OF EYE MEDICAL CARE.

PATIENT'S NAME
AGE
BIRTH DATE

HOME ADDRESS
CITY
STATE

ZIP CODE
AREA CODE
HOME PHONE
WORK PHONE

CELL PHONE
BEST TIME TO CALL
EMAIL ADDRESS

OCCUPATION (or GRADE)
EMPLOYER (or SCHOOL)

VISUAL INFORMATION

Approximate Date of Last Visual Exam
Doctor Examining

CHECK YOUR VISUAL COMPLAINTS or VISUAL REASON FOR YOUR OFFICE VISIT:

☐ Blurring at Distance ☐ Eye Fatigue ☐ Body Rigidity while looking at Distant Objects
☐ Blurring at Near ☐ Short Attention Span ☐ Turning of Head so as to use one Eye Only
☐ Problems with Reading ☐ Avoiding Close Work ☐ Moving Head rather than Eyes While Reading
☐ Broke or Lost Glasses ☐ Excessive Blinking ☐ Thrusting Head Forward / Backward -looking at Distant Objects
☐ Want Contact Lenses ☐ Frequent Rub Eyes ☐ Unusual Fatigue after Completing a 'Vision Task'
☐ Want Sunglasses ☐ Tilting Head To One Side ☐ Using Finger to keep place while reading
☐ School Referral ☐ Closing or covering one eye ☐ Placing Head Close to Book or Desk when Reading or Writing
☐ Losing Place while Reading ☐ Poor Eye -Hand Coordination ☐ Want a Work Pair - Eyeglasses
☐ Other

EYEGLASS INFORMATION:

DO YOU WEAR YOUR GLASSES WHEN YOU DRIVE? ☐ YES ☐ NO
DO YOU NEED A PAIR OF SUNGLASSES? ☐ YES ☐ NO

If Yes, Please Explain:
YOUR SIGNATURE ON THIS PAGE IS ALSO INDICATION THAT YOU WILL ALLOW AT LEAST 2 WEEKS & WILL NOT GO PAST 4 WEEKS FOR ADAPTATION IF WE PRESCRIBE A NEW RX.

WE WANT TO BE YOUR SUPPLIER OF YOUR EYEWEAR:

If you need Same Day Service, we can do it on most Lens Prescriptions. Our eyewear Prices are below other Optical Suppliers on Comparable Eyewear Product. We have a LOWEST PRICE GUARANTEE PROGRAM. THE FINAL SELECTION IN FRAMES and LENS PRESCRIPTION IS THE PATIENTS CHOICE. NO CHANGES WILL BE MADE AFTER A DEPOSIT ON RX HAS BEEN TAKEN OR PATIENT LEAVES OUR CLINIC AFTER GIVING ORIGINAL AUTHORIZATION.

CONTACT LENS INFORMATION:

(1) For Your Protection, STATE LAW OF OKLAHOMA restricts your Contact Lens Prescriptions to a CONTACT LENS FITTING with contacts on & at least one Follow-Up Visit. (2) For Your Protection, STATE LAW OF OKLAHOMA restricts your Contact Lens Prescriptions to an expiration date of ONE YEAR from your Contact Lens Fitting Date. (3) A Contact Lens Rx is not available until the Contact Lens Fitting is finalized. (4) Yearly Visual Exams are required by law to refill contact lens prescriptions past 365 days.

TO BETTER SERVE YOUR EYEWEAR NEED:

WHAT WOULD YOU LIKE TO LEARN MORE ABOUT: ☐ Laser Vision Correction ☐ Contact Lenses ☐ Polarized Sunglasses ☐ Computer Glasses ☐ Other

CHECK OR LIST ACTIVITIES / HOBBIES / SPORTS / ORGANIZATIONS / CHURCH - YOU PARTICIPATE IN THAT MAY REQUIRE SPECIAL VISION CARE:

☐ Golf ☐ Fishing ☐ Boating ☐ Hunting ☐ Tennis ☐ Bike Riding ☐ Football ☐ Basketball ☐ Baseball ☐ Softball ☐ Soccer ☐ Computer

FOR OUR RECORDS, IF YOU DO FILL THIS EYE-PRESCRIPTION, WHERE DO YOU PLAN TO HAVE IT FILLED.

(1) __________________________ (2) __________________________

MEDICATIONS:

(1) __________________________ (2) __________________________

FOR EYEGLASSES or CONTACT LENSES:

(1) __________________________

APPOINTMENTS ARE NEEDED FOR:

(1) Dispensing of Eyewear, (2) Frame Adjustments, (3) Frame Repairs

HOW WILL YOU BE PAYING FOR YOUR VISION & EYE MEDICAL EXAM TODAY?

☐ Cash ☐ Check ☐ VISA ☐ MasterCard ☐ CO-PAY ☐ VISION INSURANCE ☐ MEDICAL INSURANCE ☐ MediCare ☐ Medicare

OUR OFFICE WILL USE ONLY THE HIGHEST QUALITY OF MATERIALS, SERVICES, and EXPERTISE, THAT YOU WILL ALLOW US TO DO. WE WILL MAKE EVERY EFFORT TO HAVE YOUR EYEWEAR BY A CERTAIN DAY and TIME. WE CANNOT PROMISE or GUARANTEE THAT YOU WILL HAVE THIS RX BY THIS TIME, BUT WE CAN GUARANTEE THAT EVERY EFFORT WILL BE MADE TO DO SO! Any Lens Prescription Changes after 60 Days from the Original Dispensing Date will be at your expense, as the patient. NO MATTER WHAT THE REASON. WHEN WE PROVIDE MEDICAL PROCEDURES AND MEDICAL SERVICES, WE DO BILL MEDICAL INSURANCE WHEN WE CAN. OUR OFFICE POLICY IS NO REFUNDS ON SERVICES, MEDICATIONS, CONTACT LENS SOLUTIONS, CONTACT LENSES, EYEGLASS LENSES or FRAMES.

SIGNED
Patient

SIGNED
Parent or Guardian if Patient is a Minor

WE NEED A COPY OF YOUR VISION INSURANCE CARD (if you have one) & YOUR MEDICAL INSURANCE CARD.
AUTHORIZED

I do hereby authorize the use or disclosure of the Protected Health Information Of Medical & Visual Information described below to be provide to or obtained for the Release To the VISION & EYE MEDICAL DIAGNOSTIC LASER CENTER & Dr. R. Charles Duke ANY and ALL "REQUESTED INFORMATION" concerning care given to me by you and your staff.

This will Authorize DOCTOR _________________________ to release MEDICAL & VISION INFORMATION from your medical records in accordance with Oklahoma State Law Title 43-1, Section 1-109.

FROM DOCTOR: _________________________ PHONE #: _________________________

MAILING ADDRESS: _________________________ Fax #: _________________________

CITY: _________________________ STATE: _____ ZIP: _________________________

The information authorized for release may include information which may include information which may indicate the presents of a communicable (which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also know as AIDS) or noncommunicable disease, or relate to mental health, or drug, substance or alcohol abuse. I understand that my medical information may have a privileged and confidential status. I am waiving that status for the purpose contained within this authorization.

THE INFORMATION WILL BE OBTAINED, USED, OR DISCLOSED FOR THE FOLLOWING PURPOSE:
CONTINUED TREATMENT AND DO TO THE REQUEST OF THE PATIENT. SEND THE FOLLOWING INFORMATION TO VISION & EYE MEDICAL DIAGNOSTIC LASER CENTER & DR. DUKE:

- Medical History
- Eye Medical History
- Visual History
- Visual Acuities
- Tonometry (IOP)
- Cup / Disc Ratio
- Ophthalmoscopy
- Biomicroscopy
- Gonioscopy
- Ocular Motility
- Pupil Test
- Visual Fields
- Eye-Glass Rx
- Keratometry Readings
- Contact Lens Rx
- GDx (Nerve Fiber Analysis) or OTC
- RTA (Retina Thickness Analyzer)
- Fundus Photography
- Glucose Test
- Blood Test Results
- B- Scan or MRI

Any & All Meds Rx by you
Any & All Diagnosis Given By You
Any & All Eye Medical Treatments
Any & All Eye Surgeries By You
ANY & ALL Other Records in your Files
Information that may be Important

COPIES OF MY RECORDS FOR MY: ☐ FIRST OFFICE VISIT ☐ ALL OFFICE VISITS - ENTIRE CHART ☐ LAST OFFICE VISIT in Your Office ☐ MEDICAL RECORDS FOR THE LAST YEAR PATIENT WAS IN YOUR CLINIC

I UNDERSTAND that I have the right to refuse to sign this authorization. I FURTHER UNDERSTAND that I am authorizing the release of information from records whose confidentiality and status are protected by Federal Regulations (42 CFR, Sec 2.13) and Oklahoma State Law; and that redisclosure of this information by the receiving agency is PROHIBITED. THIS AUTHORIZATION will expire in 12 months from the date that appears below next to my signature. This authorization may be revoked at any time upon written notification by the signatory or guardian, except revocation will not apply to information already retained, used or disclosed in response to this authorization.

I release the entities listed above, their agents, staff, employees from any liability in connection with the use or disclosure of the protected information. The entity authorization to disclose will not be compensated by the recipient for such disclosure.

PATIENT'S NAME (Print): _________________________ AGE: ________ SEX: ________

DATE OF BIRTH: ________ / ________ / ________ SOCIAL SECURITY NUMBER: ________ / ________ / ________

PATIENT'S / GUARDIAN SIGNATURE: _________________________ DATE: ________

Please Fax, Mail or Email COPIES Of My Records To:

Fax: 1 (918) 266-3412 P.O. Box 98 Catoosa, Oklahoma 74015 Email: DrCharlesDuke@aol.com
**Responsible Party For Payment or Primary Insurance Card Holder:**

<table>
<thead>
<tr>
<th>Name</th>
<th>[ ] Patient</th>
<th>[ ] Father</th>
<th>[ ] Mother</th>
<th>[ ] Guardian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years</td>
<td>How Long Have You Lived At The Above Address?</td>
<td>Social Security #</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mailing Address</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>City</td>
<td>State</td>
<td>Zip</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Phone</td>
<td>Work Phone</td>
<td>Cell Phone</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Spouse’s Name | DOB | Social Security # |
| Place Of Employment | | |

**Parents Information:** (if Patient is under Age 21)

| Father’s Name | DOB | Social Security # |
| Place of Employment | | |
| Mother’s Name | DOB | Social Security # |
| Place of Employment | | |

**Other Information:**

| Nearest Relative NOT Living With You | Phone | City | State |
| Nearest Friend NOT Living With You | Phone | City | State |
| Whom May We Contact In The Case Of an EMERGENCY? | Phone | City | State |
| Whom May We **THANK** For Referring You To Us? | Phone | City | State |

**ALL VISITS ~ To Our Office YOU Must Have An APPOINTMENT**
ABOUT FINANCIAL ARRANGEMENT:

We are committed to providing you with the best possible care. If you have Visual or Medical Insurance, we are willing to help you receive your MAXIMUM ALLOWABLE BENEFITS. In order to achieve these goals, we need YOUR ASSISTANCE, and YOUR UNDERSTANDING of how and what your vision and medical insurance pays. Also, our PAYMENT POLICY with you, if we provide eye care for you. We are “DEDICATED TO EXCELLENCE”, during your VISION EXAM we will also be doing EYE MEDICAL TESTING.

PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED unless PAYMENT ARRANGEMENTS have been APPROVED IN ADVANCE by your medical insurance and or visual insurance and by our BILLING & ACCOUNTING DEPARTMENT and NOT DURING THE TIME OF YOUR EYE EXAMINATION. Our FEES are based on PER VISIT CHARGES and TYPE OF TESTING per Visit. When materials are necessary (eyeglasses or contact lenses, or lacrimal plugs) are not covered by insurance, at least One-Half of YOUR MATERIALS FEE is expected upon ORDERING. The BALANCE IS DUE UPON DISPENSING. We accept INSURANCE ASSIGNMENT when they pay for services and materials provided by the VISION & EYE MEDICAL DIAGNOSTIC LASER CENTER. We accept CASH, CHECKS, Money Orders, VISA and MasterCard.

VISUAL & MEDICAL INSURANCES, MEDICARE, MEDICAID or THIRD PARTY BILLING:

We accept Insurance Assignment with your Medical & Vision Insurance, Medicare Assignment and Medicaid Assignment with the understanding that Prior Arrangements must be made and Verification and Authorization obtained prior to scheduling your APPOINTMENT. Today and each Office Visit, EYE MEDICAL PROCEDURES will be done. Most cases all these procedures will be paid for by your MEDICAL INSURANCE, if not you will be responsible for these fees. If you have a deductible, we will still bill your insurance, to help you with your deductible. We will file with your appropriate insurance. Without Prior Arrangement or Authorization we expect to be PAID IN FULL and will be happy to help you with a CLAIM-FORM so you can be reimbursed. Authorization does not GUARANTEE that your Insurance, Medicare or Medicaid will pay, they even tell us this when we are obtaining Authorization. YOU ARE RESPONSIBLE FOR THE FOLLOWING: (1) The DEDUCTIBLE, (2) The CO-PAY on your Insurance. This is the Portion or Percentage NOT COVERED by your INSURANCE. (3) ANY NON-COVERED CHARGES by your Insurance. This is ANY CHARGES NOT PAID by your INSURANCE. WE FILE ONLY ONE TIME AT NO CHARGE, ANY ADDITIONAL TIME SPENT BY DR. DUKE’S STAFF or DR. DUKE to go over billing and collection were do charge an ADMINISTRATIVE FEE, minimum FEE of $30.00.

Hereby assign to Dr. R. Charles Duke all money from Insurance Company to which you are entitled to for Eye Medical, Surgical Expense, and/or Visual Services relative to the service rendered by Dr. Duke, including Visual Aids - such as Eyeglasses & Contact Lenses, which is owed by you to Dr. Duke. You understand and agree that you are financially responsible to Dr. R. Charles Duke for charges not covered by this Assignment.

We must emphasize that as visual and medical care provider, OUR RELATIONSHIP IS WITH YOU, not your Insurance Company. YOUR SIGNATURE ON THIS PAGE MEANS YOU HAVE READ THIS, AND YOU AGREE TO ALL DR. DUKE’S OFFICE POLICIES ON FEES FOR SERVICES AND EYEGGLASSES. While the filing of INSURANCE CLAIMS is a courtesy that we extend to our patients, ALL CHARGES ARE YOUR RESPONSIBILITY from the date the SERVICES are rendered. YOU ARE RESPONSIBLE FOR YOUR BALANCE AFTER 45 DAYS FROM THE DATE OF SERVICE. If you have not received an EXPLANATION OF PAYMENT from your INSURANCE COMPANY within 30 Days, we recommend you contact your INSURANCE COMPANY. AFTER THE FIRST FILING TO COLLECT FROM YOUR INSURANCE, WE CHARGE FEES FOR ADDITION ADMINISTRATIVE SERVICE.

ADAPTATION & EYEGLASS OFFICE POLICY:

WE DO NOT ACCEPT ASSIGNMENT ON SERVICES IF THE PRESCRIPTION IS TAKEN OUT OF OFFICE. WE DO NOT ACCEPT ASSIGNMENT ON EYE WEAR IF THE PRESCRIPTION IS FROM ANOTHER DOCTOR OUT OF OUR OFFICE. Our office uses a Computer Vision Analyzer, which means that your eyes have been read for a Prescription 8 times. This instrument has already narrowed your prescription down to just 5 lens choices. So when we take you to the Exam Room, Dr. Duke is already in the CHECK MODE, after Dr. Duke confirms that you have given the same answer 4 times, he will do an added CHECK METHOD. By doing this you have given the same answer 10 TIMES for your NEW Prescription. If a Prescription is fabricated, we ask that you allow 2 WEEKS FOR ADAPTATION and do not go past 4 weeks for ADAPTATION. Out of 5,000 patients only 3 will have changed from the Exam Date due to Medical Problems or due to Medication Interference. Because you give the same answer 10 TIMES we ask you to allow the two weeks for an Adaptive Period to avoid the possibility of paying for a needless Office Visit. If you allow Dr. Duke to examine you, this means - you waive any Agreements for Recheck & Remake Services set by an Insurance Co. A Re-Check Exam minimum FEE is $65.00 and Re-Verifications & Consultation Fee is $40.00. Phone Consultation on Adaptation Fee is $35.00, Remakes of Lens at 50% OFF and any other services do have FEES. Dr. Duke has a NO REFUND on SERVICES or EYEWEAR. Your signature on this page means that you have read this, and have agreed to Dr. Duke’s FEES.

RETURN CHECKS have a $35.00 ADMINISTRATIVE FEE. Balance older than 30 Days will be subject to COLLECTION FEES and INTEREST CHARGES of 1.75% per month, this INCLUDES INSURANCE BALANCE, MEDICARE, and Medicaid. CHARGES will also be made for NO-SHOW APPOINTMENTS and APPOINTMENTS CANCELED without 24 hours ADVANCE NOTICE.

I further agree in the event of non-payment, to bear the cost of COLLECTIONS by Dr. Duke’s Staff or an Agency, and/or court Costs. All Legal Fees and his Professional Fee for Time AWAY FROM THE EXAM ROOM and Dr. Duke’s Regular Fees for Administrative Services for in such a Case should this be required. I, also, understand that this is a On-Going Policy and my signature on this page, means that I’m agreeable to the same POLICIES and FEES of Dr. Duke, on future Office Visits, Services, and Eyewear Materials. I further agree to PAY FEES for Administrative Time required by me by Dr. Duke or his Staff, Minimum Fee of $30.00.

ALL VISITS ~ To Our Office YOU Must Have An APPOINTMENT

I UNDERSTAND and AGREE that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered or materials. I have read all the information on this sheet and have completed the answers on the back page. I have provided my current medical information, all medications I am on, and all of my eye medical complaints on your other form. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature __________________________________________ Date ____________________________