

TOB Compliance Cash Pay Patient Forms

I am requesting to have a cash pay eye health examination. I understand that once the evaluation is done by the doctor, that I am responsible for the cost of the exam for which a rough estimate of costs has been presented to me prior to the initiation of the examination.

I give Vision Source Copperfield my consent to send my glasses and contact lens information as well as results from my eye health exam through my email.

I also give my acknowledgement of the recipient of my glasses and/or contact lens prescription upon my request.

Disclaimer:

- Additional items may be required based on the results of the evaluation.
- The information provided is only an estimate of the total cost.

_____ Patient Name	_____ Patient Date of Birth	_____ Patient Signature
<u>Dr. Madeline D. Nguyen</u> Provider's Name	<u>1366456469</u> Provider's NPI	<u>261276449</u> Provider's Tax ID#

**List of Services**

Procedure Code(s):	Diagnosis Code(s):	Expected Charge(s):
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____