# VOSS VISION

**Drs. John & Kendra Voss**

(Please Print)

Date: _____

Name: _____ SS#:_____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____ Home#:_____ Work#:_____

Cell#:_____ Okay to Text? □ Yes □ No

E-mail : _____ Employer: _____ Occupation: _____

**Release of Benefits:**

"I request that payment of benefits be made to the doctor for any services provided by them. I also authorize any holder of my medical information to be released to the carrier and its agents in order to determine these benefits or the benefits payable for related services."

**Acknowledgement of Privacy Policies:**

"I have had a chance to receive a copy of the Privacy Practices and Policies of this practice."

_____ _____

Signature Date

***Retinal Imaging:**

If you have never had this screening done in our office, the doctor recommends retinal digital imaging to establish a reference point to monitor the health changes in your eyes each year. After this initial "baseline" image, Dr. Voss recommends the retinal imaging every other year. This procedure can be filed to your medical insurance when there is a medical diagnosis found; otherwise there is an additional charge of **$35 for this screening.**

_____ **Yes**, I want the screening performed _____ **No**, I do not want the screening performed

***Retinal photos may be printed upon request.**

**Primary Care Physician**: _____

**List of Medications**: _____

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