

Dr. Wayne Chan, O.D. / Studio Optics Eyecare  
229 Berkeley Street  
Boston, Massachusetts 02116  
617-247-0012 (phone or fax)

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Wayne Chan O.D / Studio Optics Eyecare's Notice of Privacy Practices.

Patient Name \_\_\_\_\_

Patient SSN \_\_\_\_\_

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

COORDINATION OF BENEFITS

I, \_\_\_\_\_ (patient name), acknowledge that:

- The doctor will submit a claim to my vision plan for all covered vision services that have been provided.
- The doctor will coordinate coverage with my vision benefit and other insurance plan that I have coverage with.

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

----- Fill below at time of exam -----

Dilated Retinal Exam  
RELEASE AUTHORIZATION

I do not wish to have my eyes dilated at this time. I am aware of the benefits of this procedure in the early detection of eye diseases, tumors, and other related conditions.

Patient Name \_\_\_\_\_

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