California Ophthalmic Laser Associates Medical Corp. Payment Authorization & Procedure Information

Patient Information:

PATIENTS NAME: (Last Name, First Name, Middle Initial)	**DATE OF BIRTH:** (Month/Day/Year)	**PATIENT'S GENDER:** ☐ Female ☐ Male
PATIENTS ADDRESS: (Street No.)	**SOCIAL SECURITY NUMBER:**	**DOES PATIENT HAVE VSP COVERAGE?** ☐ Yes ☐ No
CITY:	**HOME PHONE:** ( )	**IF YES, WHICH VSP COVERAGE?**
STATE: / **ZIP:**	**WORK PHONE:** ( )	**DOES PATIENT NEED A RECEIPT?** ☐ Yes ☐ No

Surgery Information:

SURGERY DATE: (Month/Day/Year)

EYES: ☐ OD ☐ OS ☐ OU

☐ Beverly Hills ☐ Concord ☐ Long Beach (Los Alamitos)
☐ Sacramento ☐ San Francisco
☐ San Leandro ☐ San Jose ☐ Newport Beach (Coastal Vision)
☐ Other _____

OPTOMETRIST:

SURGEON:

PROCEDURE:

☐ Lasik $ _____ per/eye ☐ Epi-LASEK $ _____ per/eye
☐ Intacs $ _____ per/eye ☐ Clear Lensectomy $ _____ per/eye
☐ PRK $ _____ per/eye ☐ w/Wavefront add $ _____ per/eye
☐ Phakic IOL$ _____ per/eye ☐ w/IntraLase add $ _____ per/eye
☐ Other: _____$ _____ per/eye
☐ Retreat $ _____ per/eye Original Surgery Date:_____

Payment Information:

GLOBAL FEE:

PAYMENT:
☐ Collect money day of surgery.
☐ Payment forward to COLA, Med.
☐ Charge patient's credit card.
☐ Financing through COLA, Med.
☐ Other _____
_____

PAYMENT METHOD (indicate split payment)

☐ Cash $ _____ ☐ Check $ _____
☐ Credit Card $ _____ ☐ Financing $ _____

Please charge my card as follows:

_____-_____-_____-_____ _____
Card Number Exp. Date

I understand that my payment will be refunded if the refractive procedure is canceled with 24 hours notice, or the surgeon elects to postpone surgery for medical reasons.

_____ _____
Cardholder Signature Date

FINANCING:

Wells Fargo $ _____
☐ 3 Months ☐ 6 Months ☐ 12 Months
(Same As Cash)

Vision Fee Plan $ _____
☐ 18 Months ☐ 24 Months
☐ 36 Months ☐ 42 Months
☐ 60 Months
(Interest Rate 5.9% - 12.9%)

COMMENTS: _____
_____

I have elected to have laser vision correction at an affiliated laser center of the COLA, Inc. Panel of Doctors. I request that my follow up care be done by my optometrist and I agree to have my refractive surgery done by an affiliated COLA, Inc Surgeon. I realize that it is usual and customary for the patient to pay the facilities and doctors separately for services they provide. However I choose to make one payment to COLA Medical Corporation and request that it be distributed as specified under the COLA Medical Corporation contracts.

Patient Signature: _____ **Date:** _____

Form Completed By:	Date Mail/Fax:

White - O.D,'s Copy **Yellow** - Patient to Bring to Surgery Center **Pink** - Patient's Copy

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