Vision Source Mandan

Authorization and Release

I authorize the release of my protected health information (PHI) including the examination, diagnosis and/or treatment rendered to me or my dependent(s) during the period of such care to third party payers, other health practitioners, pharmacies, laboratories, or any other entities that are required in order for Vision Source Mandan to function as an optometry clinic and provide patient care.

I understand it is my responsibility to present accurate insurance information at the time of the appointment. I understand it is my responsibility to know my insurance plan eligibility, benefits, and network providers. I authorize and request my insurance company to pay benefits directly to the doctor, otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services, and **I understand I am responsible** for any services or materials rendered on my behalf or my dependent(s) that my insurance does not cover. **I understand payment is due in full for any copays, overages, and non-covered services or materials at the time of the appointment**. I understand there are no refunds for services provided.

I acknowledge that I have read and agree with the above policy.

_____ _____

Signature of patient (or parent/guardian if minor) **Date**

Patient Name: _____

(Please print.)

HIPAA Privacy Practice Acknowledgment and Consent

I have received, or was offered and declined, a copy of the Notice of Privacy Practices.
I hereby agree to the policies set forth in the Notice, and any subsequent changes in policy.

Signature: _____ **Date:** _____

Vision Source® Mandan

Communications Permission

Our office utilizes email communication and text messages for appointment reminders, order updates, and more. You can also access our online patient portal.

Email: _____

Cell Phone: _____

If you would prefer to OPT OUT of these communications, initial here: _____

Federal Trade Commission (FTC) Ophthalmic Practice Rule

I consent to be provided a digital copy of my eyeglasses prescription and contact lens prescription through the online patient portal after completion of the refractive eye examination. The online patient portal is available at www.revolutionphr.com and I have been given login instructions. Prescriptions are available immediately on the portal until they expire. Even though I agree to digital receipt of my prescriptions, I understand that I can also request a paper copy at any time in-person or by USPS Mail.

I acknowledge that I have read and agree with the above policy.

_____ _____

Signature of patient (or parent/guardian if minor) **Date**

Patient Name: _____

(Please print.)

If you find it inconvenient that you must sign this form, please email the FTC and complain that the ophthalmic practice rule creates unnecessary paperwork: antitrust@ftc.gov