Vision Source Mandan

Patient Information Sheet

Would you like access to our **online** patient portal? If so, please provide an email address. *(You will not receive any spam or junk mail.)*

Email: ____

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 me with patient care.

If using insurance, I authorize and request my insurance company to pay insurance benefits directly to the doctor, otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. **I agree to be responsible for payment** of all services rendered on my behalf or my dependent(s). I understand **copays are due at the time of service**.

Please check the box:

☐ I understand that **payment is due in full at the time of service**.
If we are billing insurance, this includes any copays, overages, and services/materials not covered by the plan.

____ _________________________
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:** ________________