Vision Source Mandan

Patient Information Sheet

Would you like access to our online patient portal and receive email notifications for appointment reminders, order updates, and more? *(You will not receive spam.)*

Email: _____

Would you like text message notifications for appointment reminders, order updates, and more?

Cell Phone: _____

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 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 and overages are due at the time of service**. I understand there are no refunds for services provided.

Please check the box:

☐ **I understand that payment is due in full at the time of service.**

If 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:** _____