Dakota Eye Care

PATIENT FINANCIAL INFORMATION SHEET

I understand that payment in full is due at time of service unless other arrangements have been made.

Name of Patient: ____DOB_____________

Name of Insured: _______________________________________ DOB_____________

Policyholder address:____

Please circle one

YES NO : I authorize Dakota Eye Care Associates to leave a message concerning personal medical information on my home phone answering service.

YES NO : I am 18 years of age or older and I authorize Dakota Eye Care Associates to release my personal medical information to my parents or the person(s) named here: ______________________________________

Authorization and Release:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits 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 dependents.

I authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered to me or my child to: ______________________________

MEDICARE PATIENTS: I understand that the refraction portion of my examination is a **non-Medicare** covered service and, therefore, it is my responsibility to pay for this portion of my examination. (Your Medicare supplemental insurance MAY cover this refraction service.)

I have received or was offered and declined a notice of HIPPA privacy practices.

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Signature of patient or parent if minor **Date**

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