



PATIENT # _____

APPT DATE _____

Thank you for choosing Dakota vision Center for your eye care needs. We appreciate the confidence you have placed in us. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate before signing the form.

PATIENT INFORMATION

NAME _____ DOB _____

ADDRESS _____

E-MAIL _____

HOME # _____ CELL # _____

EMERGENCY NAME _____ RELATION _____ PHONE # _____

INSURANCE INFORMATION

VISION INS _____

MEDICAL INS _____

PRIVACY STATEMENT

We respect our legal duty to protect your private health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your healthcare services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment and will use and disclose your protected health information for treatment, payment and health care operations when necessary. The Notice of Privacy Practices contains important information regarding how your medical information may be disclosed. Please review it carefully. In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose information in order to treat you, to obtain payment for our services and to conduct health care operation involving our office. The Notice of Privacy Practices is available to you and describes these uses. You may refer to this notice before signing this form. You have the right to restrict the use and disclosures made for the purpose of treatment, payment, or health operations; however, we are not obligated to agree to the requested restriction. If we do agree, we are bound by these restrictions. **By signing below I acknowledge that I was given the opportunity to receive a copy of this Notice of Privacy Practices.**

I acknowledge that I am legally responsible for all charges in connection with the medical care, treatment and products provided by Dakota Vision Center. I understand that certain services I request today may not be a covered benefit as defined by my health insurance policy or certificate. If I decide to receive services such as deluxe frames/lenses these services may not appear on my EOB as my responsibility but I am aware that I will be financially responsible for these services. Payment from my insurance is to be paid directly to Dakota Vision Center. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. I understand that I will be responsible for any costs incurred attempting to collect an unpaid debt. I acknowledge that I have received the Notice of Privacy Practices for Dakota Vision Center. Full explanation of the Notice of Privacy Practices is located in the waiting area.

X _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR