Vision West Eye Care

Dwayne R. Ice, O.D.
825 Columbus Street, Ste E
Rapid City SD 57701
(605) 343-4703
www.visionsource-rapid city.com

PATIENT FINANCIAL INFORMATION SHEET
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name:_____ DOB:_____

AUTHORIZATION & 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 payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to Dr. Dwayne Ice's 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 records of any treatment or examinations rendered to me or my child to:

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

Signature:_____ Date:_____

If you are signing as a personal representative of the patient:
Print Name:_____ Relationship to Patient:_____

HIPAA PRIVACY PRACTICE ACKNOWLEDGMENT:

I HAVE RECEIVED or was offered and DECLINED a Notice of Privacy Practices:

Signature:_____ Date:_____

PATIENT FINANCIAL RESPONSIBILITY DISCLOSURE STATEMENT

Your signature below forms a binding agreement with Vision Source – Dr. Dwayne Ice (the provider of medical services) and the patient who is receiving medical services, or the Responsible Party for minor patients (patients under 18 years of age). Responsible Party is the individual who is financially responsible for payment of medical bills.

Medical Insurance: *We have contracts with many insurance companies, and we will bill them as a service to you.* As the responsible party, you are responsible if your insurance company declines to pay for any reason. This includes both the examination charges and the material costs involved with eye glasses or contacts.

A. If we are NOT A NETWORK PROVIDER for you plan, you will be responsible for payment at the time of service. We will submit your service charges on your behalf, if requested, to your insurance company as a courtesy for you.

The Responsible Party must:

A. Inform Vision Source of the current address and telephone number for both the patient and the responsible party.
B. Present all insurance cards prior to each appointment.
C. Verify at each visit that the information on file is current by signing our Patient Information Form.
D. Pay your co-pay at the time of service, and any overage or additional costs associated with materials purchased (i.e. Frames, Lens, Contacts) at the time the order is placed.

Returned Check/Non-Payment on Account: If payment is made by check, and the check is returned as non-sufficient funds (NSF), account closed (AC), or refer to maker (RTM), the patient or the responsible party will be responsible party will be responsible for the original check amount in addition to a $40.00 service charge. Once notice is received of the returned check, Vision Source will send out a letter to notify the patient or the responsible party. If a response is not made within 10 days from the letter date by the patient or the responsible party, the account may be turned over to our collection agency. Should collection proceedings or other legal action become necessary to collect a past due, NSF, AC or RTM account balance, the patient or the responsible party understands that Vision Source has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for service rendered. The patient, or responsible party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and attorney fees, and a collection fee of 50% will be added to the outstanding balance.

By signing below you agree to accept FULL FINANCIAL RESPONSIBILITY as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name(Please Print):_____

Patient Signature:_____ Date:_____

Responsible Party Name (Please Print):_____

Responsible Party Signature:_____ Date:_____

ALL CHARGES FOR SERVICES RENDERED ARE DUE AND PAYABLE AT THE TIME OF SERVICE