Brandon Hauck, O.D.
515-448-3813 Phone
515-448-3885 Fax

300 W. Broadway St
P.O. Box 459
Eagle Grove, IA 50533

Insurance Authorization

I authorize Broadway Vision Source, Inc to release my medical information to my medical or vision benefit plan for reimbursement on my behalf. I permit my information to be shared with billing agents and suppliers. I understand that I am responsible for co-pays, deductibles and non-covered services not paid by my insurance plan.

HIPAA

The Notice of Privacy Practices describes the uses and disclosures of patient health information that may not be made without your authorization or consent. This authorization may be used for specific uses and disclosures of information that require further authorization from you.

Please Indicate:

____ YES- I would like a copy of the HIPAA Privacy Policy _____ NO- I decline a copy of the HIPAA Privacy Policy

Emergency Contact

Name: _____ Phone#: _____

Prescription Acknowledgement

I understand that after paying my fees my prescription belongs to me and I am able to get a copy at any time while valid. All contact lens prescriptions expire one year from the date of exam, and all glasses prescriptions expire two years from the date of exam.

Additional Testing

An i-wellness test may be done to help in diagnosing or monitoring certain conditions, this test is often not covered by insurance and will result in an additional charge. I acknowledge that I will be responsible for this charge.

Medical vs. Routine

Routine vision exams may turn into a medical exam depending on the condition or diagnosis found during my exam, if a medical diagnosis is found the exam charges will be submitted to my medical insurance. I acknowledge that I will be responsible for the charges determined by my insurance.

Cancellation/No Show Policy

I acknowledge that Broadway Vision Source has the right to refuse to rebook me if multiple no shows occur. They may also only offer me same day appointments, require my charges upfront and/or charge a no show/rebooking fee prior to being seen in their office again.

Affirmative Consent to Provide Information Electronically

I consent to Broadway Vision Source, Inc using electronic means (text messaging, email, fax, web portal) to transfer my information to myself, pharmacies, phsicians, insurance companies etc.

Patient Signature _____ Date _____

(Guardian if patient is a minor)