☐ RICHARD J. ARNESON, O.D.
☐ ERIC D. ARNESON, O.D.
OPTOMETRISTS

Hastings Vision Clinic
2119 West 12th St. • Hastings, NE 68901-3605
Ph.: (402) 462-8816 • Fax: (402) 462-8050

HIPAA COMPLIANCE ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I received a copy of Notice of Privacy Practices.

Date ______________________________

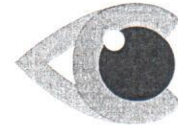
Patient Name ____

Signature ____

Richard Arneson, OD
Eric Arneson, OD

Address 2119 W. 12th Street
Hastings, NE 68901-3605

Phone 402-462-8816
Fax 402-462-8050
Web HastingsVisionClinic.com



Hastings
Vision Clinic

1. **Secure Email**

We are requesting your email address for a secure email. When you give us your email we will send you a link to the secure site where you can look at or download your personal records. This is **NOT** a public site. You will have access to your exam records, prescription etc. We can also email you letting you know your glasses and or contacts are ready to be picked up.

Please initial one Agree______Disagree______

2. **Patient Authorization** (Reverse side of paper)

I request that payment of authorized insurance benefits be made to Hastings Vision Clinic P.C. for any services furnished, regardless of insurance benefits. I am responsible for payment of all charges. Accounts left unpaid will be turned over for collections unless other arrangements are made. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents.

Please initial one Agree______Disagree______

3. **Request for Release of Information**

If you are a new patient to Hastings Vision Clinic we would like to have your last exam faxed to us to compare your prescriptions.
I, request my information to be released to the Doctors of Hastings Vision Clinic.

Please initial one Agree______Disagree_______

4. **Billing Policy**

Before the patient leaves the office, All Co-pays MUST be collected on the day of service. When placing a glasses order patient MUST pay at least ½ of the balance before the order is placed. The other ½ is due at the time of pick up.

Patient's Full Name__________________________ DOB________________________

Current Address and/
or Previous:________________________________ E-mail_______________________

________________________________ Employer______________________

Patient Phone Number______________________ Text YES____Declined____

Signature_________________________________

(Please fill out back side)

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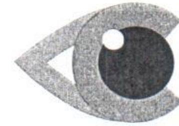

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Patient Authorization Information

Patient Name______________________________________ Date__________________

Patient Signature__________________________________
(If minor guardian signature)

Name of Health Insurance____________________________

Policy Holder Name_________________________________

Policy Holder Employer______________________________

Policy Holder DOB__________________________________

Relationship to Policy Holder_________________________

Hastings Vision Clinic may disclose your relevant medical information to family members, other relatives, or friends/others you designate who are involved in your care. To understand your wishes, we ask each patient to designate in writing those individuals who may receive information relating to your care at Hastings Vision Clinic. For example, we may give test results by phone to such individuals or allow such individuals to pick up your prescriptions, eye wear or contact lenses when you are not available. This form does not alter our ability to communicate with family members, or others involved in your care that are not designated above, in the event of an emergency or other circumstance in which you are unavailable, and in our professional judgement, we believe it is in your best interest to do so.

I designate the following individuals to receive information regarding my care and services or charges for my care and services at Hastings Vision Clinic.
(If none, please check at right): ______None

Name	Relationship to Patient	Phone number

Signature:____ Date:______________