



Jessica Ahmann, OD

1100 31st Ave SW Suite 2
Minot, ND 58701
701-837-0022

_____ 1. Insurance information/card must be presented at the time of service or exam and any materials. I understand that Optical Outlook will bill my insurance and accept payment for the services provided which may include my most recent vision exam, any special testing or procedures that may be performed and/or purchase of glasses or contacts. I also understand that insurance plans change and Optical Outlook may not be familiar with my insurance benefits or be able to fully determine whether my insurance company will pay for all or part of my services. In the event that my insurance does not provide full reimbursement to Optical Outlook, I agree to be responsible for any charges beyond my plan allowance, co-insurance or any deductible that may apply. If we are not providers with your insurance out of network charges may apply. Any overpayment, will be refunded to me, any underpayment will result in a balance due by me at that time.

_____ 2. Glasses are a medical prescription and are non-refundable, contact lens returns may be subject to a restocking fee.

_____ 3. My signature below acknowledges my review of the posted Notice of Privacy Practices Policy of Optical Outlook describing my rights under the Health Insurance Portability and Accountability Act of 1996. In addition, my signature gives Optical Outlook permission to disclose my vision related health information, to process my eyewear order, to provide me with postcard exam reminders and to leave phone messages at my primary residence.

Ok to share PHI with Parents/Spouse _____

Patients Name _____

Patients Signature _____

Date: _____

Legal Guardians Signature _____

I authorize Optical Outlook to you this signature for any insurance submissions for a period of 5 yrs from the date above.