JACOBY J. DEWALD O.D.
GREAT PLAINS VISION CENTER

Welcome! We are happy you are here!

PLEASE PROVIDE ALL INSURANCE CARDS FOR THE RECEPTIONIST TO PHOTOCOPY. IF WE DO NOT HAVE AN UPDATED COPY, YOUR COST WILL BE $105 FOR A CASH PAY EXAM

PATIENT PORTAL

GPVC offers access to our online portal. There you can view your account balance, review prior exam notes, and you will have access to your eyeglass and/or contact lens prescriptions.

- ☐ Please text my username and password to _____
- ☐ Please email my username and password to _____
- ☐ I am not interested in using the portal, but thank you!

GPVC PAYMENT POLICY

Payment for services, including copays (vision and/or medical), are due at the time services are rendered.

For glasses or contacts, at least half payment is due before the order will be placed. The other portion can be paid at pick up. **Glasses and contacts must be paid in full before leaving our office.**

By signing below, you authorize Great Plains Vision to bill any necessary testing to medical insurance and are financially responsible for any charges not paid by insurance, including deductibles and copays.

Signature:_____
Date:_____

APPOINTMENT NO SHOW POLICY

When you schedule an appointment with Dr. Dewald, we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment, please let as know with enough time to give another patient a chance to take that appointment time.

- ➔ A patient who fails to show up without notifying our office is considered a “NO SHOW” and will be charged a fee of $35 at the next visit.

Signature:_____
Date:_____

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NOTICE OF PRIVACY PRACTICES (HIPAA)

I have been provided a copy of Dr. Jacoby J. Dewald's notice of privacy Policy.

Date:_____
Patient Date of Birth:_____
Patient Name:_____
Signature:_____
Address:_____Zip Code:_____
Phone:_____

- ☐ If you do not want text reminders, please check this box

If patient is a minor, signature of legal guardian
_____

Please list anyone who may have access to patient records here:
_____

MEDICARE PATIENTS ONLY:
Advance Beneficiary Notice of Non-Coverage (Medicare ABN)
Medicare considers the service listed below as a NON-Covered Service.

92015 REFRACTION—---Your cost due today will be $40.

Please reach out to 1-800-MEDICARE with any questions.

I understand the Refraction (Vision Test) is not covered by medicare and will be the responsibility of the patient.

Signature:_____
Date:_____