DR. BRADLEY R. YAKLICH
626 E. Lincolnway, Suite B
Morrison, IL 61270
815.772.7455
www.visionsource-morrison.com

PATIENT CONSENT FORM

Patient name: _____ Date of Birth: _____

Address:_____

City: _____ State: _____ Zip:_____

Home Phone: _____ Work Phone:_____

Cell Phone:_____ Email:_____

Place of Employment: _____ Occupation: _____

Insurance Cardholder Name: _____ /Date of Birth: _____

Did anyone refer you to our office, if so who:_____

Social Security Number: _____

I, _____, consent Dr. Yaklich to the release of medical records for the above specified individual.

Please read carefully:
I authorize the release of any medical or other information necessary to process insurance claims for any services furnished to me. Insurance that Dr. Yaklich is a provider for, I request payment of authorized benefits be made directly to him.
I understand that my medical records are confidential. I understand that by signing this consent form I am allowing my medical information to be released upon request, for the purpose of Health Care Operations (including, but not limited to, provider review functions, claims payment and quality assessment). I also understand that I may revoke this consent by written request at any time with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.
I agree to pay all charges due and understand that insurance deductibles and co-payments are my financial responsibility, as are charges for which my insurance may deny payment. I understand that I am responsible for payment of any collection costs incurred on this account, attorney and court fees and other legal expenses.
Vision Source has my permission to send me a recall card in the mail for the purpose of notifying me of the need to schedule an upcoming appointment.
Vision Source has my permission to call me at home, place of business, leave a message with someone at my residence or to leave a message on my answering machine, for the purposes of notifying me of an upcoming scheduled appointment or the need to pick up glasses or contacts.

Patient Signature: _____ Date:_____