VISION SOURCE EYECARE

WELCOME TO OUR OFFICE

Patient Name: _____ Today's Date: ____/____/____

Patient Age: _____ Date of Birth: _____ Male ☐ Female ☐

Occupation: _____ Social Security #: _____ Phone: _____

Address: _____

Name/Date of birth of **Primary Insured** : _____ DOB ____/____/____

EYECARE HISTORY

Last Eye Exam: _____ By whom: _____

Have you been diagnosed with any of the following: (Please Check)

☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Strabismus ☐ Amblyopia/Lazy Eye

Are you currently using any prescription eye drops? Y N If Yes, for what?_____

MEDICAL HISTORY

Have you been diagnosed with any of the following: (Please Check)

☐ Diabetes* ☐ High Blood Pressure ☐ High Cholesterol ☐ Rheumatoid Arthritis ☐ Thyroid Disease

***If Diabetic please complete: Recent Blood Sugar : _____ Most Recent A1C: _____**

How many times a day do you use artificial tears? _____ Are your eyes ever watery? Y N

Do you plan to get new glasses today? Y N

FOR OFFICE USE ONLY ☐ NEW ☐ ESTABLISHED Doctor Today _____

Vision Insurance: _____ Medical Insurance: _____ Copay: _____ Self Pay: ☐ Y ☐ N

Ht: _____ Wt: _____ BP: _____/_____

Reason for Today's Visit (CVC): ☐ Full ☐ Red Eye ☐ Dry Eye ☐ Glc1/OCT ☐ CL ck ☐ Post-op IOP OD _____ OS _____

OLD Glasses RX:OD:_____ OS:_____ Add:_____

NEW Glasses RX:OD:_____ OS:_____ Add:_____

Lens Type: ☐ PAL ☐ SV ☐ TRANS ☐ Computer

OLD CL RX:OD:_____ OS:_____ Brand:_____

NEW CL RX:OD:_____ OS:_____ Brand:_____

☐ ORDER TRAILS

☐ New Wearer ☐ Sph ☐ Toric ☐ MF ☐ RGP ☐ Medically Necessary ☐ SynergEyes

Follow Up: ☐ 1mo 3mo 6mo ☐ 1 yr Other:_____

F/U Reason: ☐ Full ☐ Glc 1 ☐ Dry Eye Other:_____

VF Optos CL Ck IOP Ck P/O Macula OCT RX Ck

☐ Oasis Tears (25) ☐ Oasis Tears + (30) ☐ Pro Omega(35) ☐ DHA(50) ☐ Sauflon (9) ☐ Cliradex (30)

Photos: ☐ **Yes** ☐ Delay ☐ Refused **Photos Bill:** ☐ **Patient** ☐ 19 ☐ 24 ☐ 35 ☐ Insurance

Pmt Type: _____ Pmt Amount:_____

Notice of Privacy Policies & Consent Form

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; (4) other aspects of payment described in our Notice of Privacy Policies. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You may obtain an updated copy here at the office (or from our website).

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You also signify that you have received a copy of this Notice of Privacy Practices.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our Notice of Privacy Practices, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Insight Eyecare Specialties.

Payment Policy

It is our mission to provide you with the highest quality eyecare. In order to do this we must receive payment for our services in a timely manner. Our policy is to collect payment at the time of service. WE will file medical insurance for you when we are members of the provider panel. If we are not members, you will be required to pay for your services and/or products and then file for any reimbursement. If you have not met your insurance deductible, you will be required to pay for all products and services. We accept cash, personal check, money orders, Visa, MasterCard and Discover. All outstanding balances over 90 days old will begin to accrue interest at a 10% APR. We are available to discuss any questions or concerns that you may have regarding our payment and collection policy. We appreciate you as a patient and thank you for allowing us to continue to provide the highest quality eyecare.

Acknowledgement of Privacy & Payment Policies:

_____ _____ _____

Responsible Party Signature Relationship to patient Date

Please print patient name here. _____

CONTACT INFO

Our practice strives to correspond in the most efficient and timely manner when it pertains to patient communication. We offer the option of confirming appointments, reminders and sending occasional offers through electronic communication methods. Please help us update your records to provide these enhanced services.

_____ _____ Texting OK? (circle one)

Email Address Cell Phone Yes No