

WELCOME TO VISION SOURCE EYECARE

Reason for Today's Visit (circle one): ☐ Yearly Exam ☐ Urgent Eye Concern ☐ Scheduled Follow Up ☐ Other ☐

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

Address: _____ Zip Code: _____ SSN: _____

Patient Age: _____ Date of Birth: ____ / ____ / ____ Please Circle: ☐ Female ☐ Male

Occupation : _____ Phone Number: (____) _____ - _____

Primary Insured Name (if not patient): _____ Primary Insured Date of Birth: ____ / ____ / ____

EYECARE HISTORY: Last Eye Exam (if not here): _____ Last Eye doctor: _____

MEDICAL HISTORY: (circle Y or N)

Diabetes ☐ Y ☐ N ☐ If Yes ☐ Type 1 ☐ Type 2

Thyroid Disease ☐ Y ☐ N

High Blood Pressure ☐ Y ☐ N

Do you Plan to get New Glasses Today: ☐ Y ☐ N

Do you Currently wear Contact Lenses: ☐ Y ☐ N

Do you want Contact Lenses today : ☐ Y ☐ N

Do you have dry, itchy or watery eyes: ☐ Y ☐ N

CLINIC USE ONLY: _____ New _____ Estab **TODAYS EXAM:** Medical Routine Vision Doctor: _____

MEDICAL INSURANCE: : _____ **RVC** Y N Copay: _____ **VISION PLAN:** VSP EYEMED OTHER: _____

PREVIOUS MEDICAL DIAGNOSIS: DRY EYE MACULAR DEG GLAUCOMA CORNEA DZ OTHER: _____

CLINIC: BP: ____ / ____ **IOP:** OD ____ OS ____ **OPTOS SCREENING:** Y N **OCT SCREENING:** Y N

Current Glasses Rx: OD _____ OS: _____ Add: _____

Current CL Rx: OD: _____ OS: _____ Brand: _____

Your Personalized Vision and Eye Health Care Solution

GLASSES RX:

- ☐ SV
- ☐ PAL (or ST)
- ☐ SUNGLASSES PL RX
- ☐ TRANSITIONS
- ☐ ESSILOR COMPUTER LENS
- ☐ EYEZEN: Start 0 1 2 3 4

CL FIT

- ☐ SPHERE
- ☐ TORIC
- ☐ MULTIFOCAL
- ☐ SPECIALTY
- ☐ MED. NEC
- ☐ RGP
- ☐ I&R (\$40)

TREATMENT

- ☐ DVS VITAMIN
- ☐ WIZARD MASK
- ☐ UPNEEQ
- ☐ PURE & CLEAN
- ☐ VITREOUSHEALTH

TREATMENT

- ☐ DRY EYE MASK
- ☐ TG OMEGA 3 FISH OIL
- ☐ OPTASE INTENSE
- ☐ MACUHEALTH
- ☐ MACUHEALTH PLUS
- ☐ REGENER-EYES LITE

New CL Rx: OD _____ OS: _____ Brand: _____

New GL Rx: OD _____ OS: _____ Add: _____

TODAYS EXAM:

COB RVC
BILL MEDICAL
BILL VISION PLAN
REFRACTION TO PT
OPTOS: 29 35 INS
SCHEDULE:
ROUTINE/ANNUAL
MEDICAL FOLLOW-UP

MEDICAL EXAM:

_____ WEEKS MONTHS
DIABETIC EXAM GLAUCOMA
AMD MEIBOFLOW
DRY EYE IPL LIPIFLOW
ANTERIOR SEG POSTERIOR SEG
SPECIALTY CL FIT TEAR CARE VT
OTHER: _____

TODAYS VISIT:

MED VISION
COPAY: _____
REFRACTION: _____
OPTOS: _____
GLASSES: _____
CIS: _____
TOTAL: _____

REFERRAL

CATARACT _____
LASIK/RLE _____
EYELIDS _____
RETINA _____
PAYMENT TODAY:
CASH CC CARE CREDIT
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 eye care. 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 checks, 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

By typing your name in the field below, you acknowledge and agree that your typed name constitutes your electronic signature and is the legally binding equivalent of your handwritten signature.

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.

Email: _____

Cell Phone: _____

Texting OK? (circle one) ☐ Yes ☐ No