VISION SOURCE™
INSIGHT EYECARE

Welcome to Our Office

Today's Date _____
Name _____
Street _____
City _____ State _____ Zip _____
Primary Phone _____
Secondary Phone _____
Employer/School _____
Occupation/Grade _____
Social Security Number _____
Date of Birth _____ Age _____ Sex ☐ Male ☐ Female
Email Address _____
Who may we thank for referring you to our office?
Name of Friend/Relative _____
If not referred, how did you choose our office?
☐ Another Doctor ☐ Insurance List
☐ Saw Sign/Building ☐ Internet Search

INSURANCE INFORMATION

Vision Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____

Primary Medical Insurance _____
Subscriber Name _____
Member ID _____
Subscriber Birth Date _____

PRIMARY CARE INFORMATION

Name of Family Physician _____
Office Phone Number _____
Date of Last Physical Exam _____

PATIENT AND FAMILY HEALTH HISTORY

Please notate whether relation is maternal/paternal.

Blindness	☐ Self	☐ Relation _____
Cataracts	☐ Self	☐ Relation _____
Corneal Abrasion	☐ Self	☐ Relation _____
Corneal Transplant	☐ Self	☐ Relation _____
Diabetes	☐ Self	☐ Relation _____
Eye Infection	☐ Self	☐ Relation _____
Eye Injury	☐ Self	☐ Relation _____
Glaucoma	☐ Self	☐ Relation _____
Heart Disease	☐ Self	☐ Relation _____
Iritis/Uveitis	☐ Self	☐ Relation _____
Lazy Eye	☐ Self	☐ Relation _____
Macular Degeneration	☐ Self	☐ Relation _____
Retinal Detachment	☐ Self	☐ Relation _____

PATIENT MEDICAL HISTORY

List Current Medications (prescriptions and/or over the counter—including eye drops, vitamins, birth control, etc.)

_____
_____
_____

Allergies to Medications? ☐ No ☐ Yes
What kind? _____
Do you smoke? ☐ No ☐ Yes
Do you drink? ☐ No ☐ Yes
How many drinks per week? _____
Do you use illegal drugs? ☐ No ☐ Yes
What kind? _____
Have you been diagnosed with the following diseases?:

☐ Allergies ☐ Asthma ☐ Arthritis
☐ Cancer ☐ Cholesterol ☐ Diabetes
☐ Heart Disease ☐ High Blood Pressure ☐ Kidney
☐ Nerves ☐ Thyroid
☐ Other _____

PATIENT EYE HISTORY

Date of Last Eye Exam _____
By Whom? _____
Do you currently wear contact lenses? ☐ No ☐ Yes
What Kind? _____
Solutions Used? _____
Any Problems? _____
Interested in a new contact lens design? ☐ No ☐ Yes
Do you currently wear glasses? ☐ No ☐ Yes
Any Problems? _____
Interested in thinner or lighter lenses? ☐ No ☐ Yes
Do you currently experience…

☐ Blurry Vision ☐ Burning ☐ Crossed Eye
☐ Double Vision ☐ Dryness ☐ Flashes of Light
☐ Floaters/Spots ☐ Grittiness ☐ Headaches
☐ Itchiness ☐ Sunlight Sensitivity
☐ Tearing ☐ Trouble Seeing at Night

Please complete the following statements:

I work on a ☐ laptop / ☐ desktop _____ hours a day.
I spend _____ hours a week outdoors.
I have prescription sunglasses. ☐ No ☐ Yes
I prefer to not wear my glasses at times. ☐ No ☐ Yes
I have children. ☐ No ☐ Yes
My hobbies/interests are _____
_____

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HIPAA— Notice of Privacy Practice

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Vision Source InSight Eyecare may use or disclose your health care information. The notice also explains the rights that you are guaranteed under HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have received the notice.

Vision Source InSight Eyecare has always taken great care to protect the integrity and confidentiality of your health care information; we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have received the notice.

Signing below indicates that you have received the Notice of Privacy Practice. If you have any questions, please contact our HIPAA Compliance Officer listed: *Dr. David Sweeney, Compliance Office*

I hereby acknowledge that I have received a copy of the Vision Source InSight Eyecare Notice of Privacy Practice.

Name: _____ Date of Birth: ____ / ____ / _____

Signature: _____ Today's Date: ____ / ____ / _____

Permission to Share Medical Information

My medical information may be obtained and exchanged verbally to:

Name: _____

Relationship: _____

Permission to Bill Your Insurance

Be aware that your insurance is a contract between you and your insurance company. We will submit a claim to your insurance company; however, if your insurance company has not paid us within 45 days, the balance is your responsibility. After three statements, your account may be sent to an outside collection agency.

I have read, understand, and agree to the insurance assignment and financial policies stated above.

Signature of Patient or Guarantor: _____

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We pride ourselves on providing our patients with the best possible standard of care. **We now perform the iWellness Retinal Exam on all our patients during each annual eye exam.** The iWellness Retinal Exam allows our doctors to capture images of the back of your eye, where potential vision threatening diseases can be found—including **diabetes, glaucoma, certain types of cancer, retinal tears, and cardiovascular disease.**

You will NOT need to be dilated after the iWellness is captured.

As part of your examination work up, we will capture high resolution digital retinal imaging for review with the doctors during your examination today. **There is a $58 co-pay for the iWellness Retinal Exam, that is not covered by your vision insurance company.** Any questions you have about the iWellness Retinal Exam can be directed to your doctor, when they review the images with you during your exam.

☐ I would like to do the iWellness Retinal Exam, so that the doctor can thoroughly examine my eye health.

**** Due to COVID-19, and our attempt to minimize patients' time in the office, we are not offering dilation. Please speak with a staff member with any concerns regarding the $58 co-pay for the iWellness Retinal Exam. ****

I have read, and understand, this document:

Signature: _____ Today's Date: ____ / ____ / _____

VISION SOURCE™
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Annual Contact Lens Program

At Vision Source Insight Eyecare, we carry the latest in contact lens technology, and specialize in the most complex contact lenses. This includes astigmatism-correction (toric) lenses, multifocal lenses, corneal disease (i.e., keratoconus) lenses, and post-surgical contact lenses. We are dedicated to your health and an enjoyable, comfortable contact lens experience; that is why we have the contact lens guarantee program. If you are not happy with your contact lenses, we will buy back any unopened boxes within 90 days of your initial evaluation.

A **Contact Lens Evaluation Fee** is necessary to renew the current contact lens prescription and monitor the health of your eyes; the fee is not included in the comprehensive eye examination. The contact lens evaluation includes precise measurements, an analysis of your vision needs, and recommendations specifically tailored towards you. The evaluation also includes diagnostic contact lenses, to ensure the proper fit of the lenses and good ocular health.

The **New Patient Contact Lens Evaluation Fee** will range in price, depending on the complexity of the fit:

- **Standard** Contact Lens Evaluation (Soft Spherical Daily Wear)……..$88
- **Premium** Contact Lens Evaluation (Toric, Extended Wear, Multifocal)……$117-$148

A **Contact Lens Evaluation, or Re-Evaluation,** is necessary on an annual basis. This fee is in addition to the comprehensive eye examination fee. The fee will cover the initial evaluation and all contact lens related follow-up visits, for a period of 90 days. If necessary, it will also include the cost of any additional contact lens training classes.

- **Standard** Contact Lens Evaluation (Soft Spherical Daily Wear)……..$72
- **Premium** Contact Lens Evaluation (Toric, Extended Wear, Multifocal)……$88-$128

NOTE: These prices do not include Gas Permeable, Rigid Gas Permeable, Medically Necessary, or Ortho K Overnight Contact lenses. Please contact our billing department, for further information regarding specialty contact lenses.

I have read, understand, and agree to the annual contact lens program policies stated above.

Signature: _____ Today's Date: ____ / ____ / _____