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 ________________________________

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 _______________________

PHARMACY INFORMATION

Name of Pharmacy ______________________________

Pharmacy Phone Number _________________________

Pharmacy Address ______________________________

PATIENT AND FAMILY HEALTH HISTORY

Please notate whether relation is maternal/paternal.

Condition	Self	Relation
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? _____________________________

Do you currently wear glasses? ☐ No ☐ Yes

Any Problems? _____________________________

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 ____________________

____

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. Rachael 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: ____

Vision Source™

INSIGHT EYECARE

We pride ourselves on providing our patients with the best possible standard of care. **The standard of care, for an annual comprehensive eye exam, requires that a doctor conducts a retinal evaluation every year.** The evaluation is where potential vision threatening diseases can be found, such as diabetes, glaucoma, certain types of cancer, retinal tears, and cardiovascular disease. There are two ways that our providers can check the health of the retina: The iWellness Retinal Exam or dilation.

The iWellness Retinal Exam includes two in-office instruments, that capture holistic imaging of the back of the eye. The first instrument obtains a wide field, 200˚ view of the back of the eye. The second instrument identifies the different layers of the eye and ensures there are no abnormalities between each layer of the retina. The data acquired by both instruments, allows our providers to monitor and compare progression more adequately, year to year. **The iWellness Retinal Exam is not covered by any vision or medical insurance, and costs $58 out-of-pocket.**

Dilation includes a series of eye drops, that the doctor will administer to enlarge the pupil. The dilation process takes approximately 20-30 minutes, in order for the drops to take effect. Once fully dilated, the doctor will use a magnification lens to view the back of the retina and evaluate for abnormalities. The dilation drops have side effects, including blurred vision for 6-8 hours and extreme light sensitivity. **Dilation is fully covered by vision insurance only and has no additional out-of-pocket expenses.**

Please select one of the following options:

☐ I would like to do the iWellness Retinal Exam, for an additional $58.

☐ I would prefer pupil dilation; I am aware that my vision will be blurry, and that my eyes will be light sensitive, for the next 6-8 hours.

I have read, and understand, this document:

Signature: ________________________ Today's Date: _____ / _____ / _________

INSIGHT EYECARE

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 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 fee will cover the initial evaluation and all contact lens related follow-up visits, for a period of 90 days.

Contact Lens Evaluation Fees range in price, based on the complexity of your prescription and your eyes. Most vision insurances provide a 10-15% discount off the Contact Lens Evaluation Fee. Insurance providers consider contact lenses to be elective; therefore, the Contact Lens Evaluation Fee is not included under the annual comprehensive eye exam coverage.

New Patient – Contact Lens Evaluation Fees

- **Soft** Contact Lens Evaluation..........$88 - $148
- **Hard/Ortho-K/CRT** Contact Lens Evaluation..........$1,400 - $2,000
- **Gas Permeable** Contact Lens Evaluation..........$198 - $598

Established Patient – Contact Lens Evaluation Fees

- **Soft** Contact Lens Evaluation..........$72 - $128
- **Hard/Ortho-K/CRT** Contact Lens Evaluation..........$300 - $500
- **Gas Permeable** Contact Lens Evaluation..........$117 - $598

NOTE: The above fees do not include Medically Necessary Contact Lenses or Scleral Contact Lenses. Please ask a member of our front desk team, if you have any questions regarding the evaluation fees.

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

Signature: __________________________________ Today's Date: _____ / _____ / _________