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.

Blindness	☐ Self	☐ Relation	_____
Cataracts	☐ Self	☐ Relation	_____
Corneal Abrasion	☐ Self	☐ Relation	_____
Corneal Transplant	☐ Self	☐ Relation	_____
Diabetes	☐ Self	☐ Relation	_____
Eye Surgery	☐ 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	_____
Myopia/Nearsightedness	☐ 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

Have you been diagnosed with the following diseases?:

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

PATIENT EYE HISTORY

Date of Last Eye Exam _____
By Whom? _____

Do you wear contact lenses (CL)? ☐ No ☐ Yes
Current CL Brand: _____
Current CL Prescription: _____

Do you want an updated CL prescription? ☐ No ☐ Yes
Do you currently wear glasses? ☐ No ☐ Yes
Did you want to purchase new glasses? ☐ 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:

I work on a ☐ laptop / ☐ desktop _____ hours a day.
I spend _____ hours a week outdoors.
I have prescription sunglasses. ☐ No ☐ Yes
Do you 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. 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 care. **An annual comprehensive eye exam requires that a doctor conducts a retinal evaluation every year, to screen for threatening diseases, 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 scans that capture holistic imaging of the back of the eye. One is a wide field photo of the back of the eye. The second scans the different layers of the retina and ensures there are no abnormalities between each layer. Scanning and photo documentation allows our providers to monitor and compare progression year to year. These scans allow for earlier detection of disease than dilation alone; however, dilation may still be medically indicated under certain circumstances. **The iWellness Retinal Exam is $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 for the drops to take effect. 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 some light sensitivity. **Dilation is included in an annual exam and has no additional out-of-pocket expense.**

Our providers recommend the iWellness Retinal Exam be completed on an annual basis.

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: _____ / _____ / _____

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 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: _____ / _____ / _____