Welcome to Vision Source

Please be advised, should a patient present with a medical issue or if the Doctor uncovers a medical issue, your medical insurance will be billed and the patient will be responsible for all co-payments and deductibles at the time of service.

Today's Date: _____

Patient's Name _____

Parent or Guardian _____

Address _____ **City** _____ **State**___ **Zip** _____

Cell Phone _____ **Home Phone** _____ **Work Phone**_____

Email Address _____ **Patient Social Security Number**_____

Employer/School_____ **Occupation/Grade**_____

Date of Birth_____ **Age**____ **Sex M F** **Martial Status** ___

Name of your family physician_____

What is the major purpose of this visit? _____

What problems do you have with your current contacts or glasses?_____

Person Responsible for Account _____

Person's allowed to receive personal information about patient: _____

Please read below and sign.

- 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.
- We have a comprehensive Notice of Privacy Practices that describes these uses and disclosure in detail. You are free to refer to this Notice at any time before you sign this consent document.
- 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.
- I hereby authorize Vision Source Alexandria to apply for benefits in my behalf for covered services. I agree to assume responsibility for full payment of any remaining balance that is not covered by my insurance.
- I understand that if I present with a medical issue or the Doctor uncovers a medical issue, my medical health insurance will be billed and I will be responsible for any applicable co-payments or deductibles at the time of service.
- For the protection of patients, doctor and staff our office is equipped with video cameras.

Signature: _____ **Relationship to patient:** _____

Vision Source is dedicated to patient satisfaction through excellence in eye health care; knowledgeable, friendly service; and the finest eyewear products available.

Medical History Form

Vision Source
Lacy B. Shaw, O.D.

General Information:

Patient Name _____ Patient Date of Birth _____

Guardian Name if Patient is a Minor_____ _____

Do you wear contact lens? Yes No Do you currently use tobacco products? Yes No Are you a former smoker? Yes No
Do you use recreational drugs? Yes No Are you currently pregnant or nursing? Yes No Do you drink alcohol? Yes No

Medical History:

Please rate your current physical health (1-10, 10 being the best) _____ Date of Last Physical Exam _____
List any hospitalizations or surgeries _____

_____

List any medications you are currently taking. _____

List any medications you are allergic to. _____

Health Conditions: (Please indicate if you have any of the following conditions by checking Yes or No)

	Yes	No		Yes	No		Yes	No
Acid Reflux			Drug/Alcohol Addiction			Parathyroid Disease		
ADHD			Emphysema/COPD			Psychiatric Care		
AIDS/HIV Positive			Epilepsy or Seizures			Anxiety		
Alzheimer's Disease			Fibromyalgia			PTSD		
Anaphylaxis			Frequent Headaches			Radiation Treatments		
Anemia			Glaucoma			Seasonal Allergies		
Arthritis/Gout			Heart Attack			Shingles		
Artificial Heart Valve			Heart Issues			Sickle Cell Disease		
Asthma			Heart surgery/Pacemaker			Sinus Problems		
Autism			Hemophilia			Skin Rash/Hives		
Blood Disease			Hepatitis (Type _____)			Sleep Apnea		
Cancer			Herpes			Spina Bifida/Scoliosis		
Chemotherapy			High Blood Pressure			Stomach/Intestinal Disease		
Chest Pains			Year Diagnosed _____			Stroke		
Cholesterol Issues			Low Blood Pressure			Tachycardia/Bradycardia		
Convulsions			IBS/IBD/CROHN'S			Thyroid Disease		
Depression			Kidney Problems			Hypo		
Diabetes/Hypoglycemia			Liver Disease			Hyper		
Insulin Dependent			Lupus			Tuberculosis (TB)		
Non-Insulin Dependent			Mitral Valve Prolapsed			Tumor/Growth		
Year Diagnosed _____			Multiple Sclerosis			Venereal Disease		
Dizziness			Neck or Back Problems			Weight Loss (Unexplained)		
OTHER AILMENTS NOT LISTED:								

I understand the above information and attest that this information is accurate and complete to the best of my knowledge.

Signature _____ **Date** _____

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Acknowledgement of Receipt of Notice of Privacy Practices
Vision Source Alexandria, L.L.C.

Patient Name: _____

I acknowledge that I have been offered or received the *Notice of Privacy Practices* from Vision Source Alexandria, L.L.C.

_____

Signature Date

INSURANCE/BILLING POLICY

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not with Vision Source Alexandria, L.L.C. As a courtesy to our patients, we will file your visit with your insurance company.

NOTE: Patients are responsible for any co-pays and/or deductibles required by their insurance company at the time of their visit.

Patients will be asked to provide **both** vision plan and major medical plan information before being seen by the doctor. Our doctors are trained to diagnose and treat most ocular diseases and all patients receive a **COMPREHENSIVE EYE HEALTH EXAMINATION.**

Routine Vision Exams will be filed with the patient's Vision Plan if appropriate. A routine exam is defined as any exam where **NO** medical diagnosis is found. Examples of routine diagnosis include; myopia (nearsightedness), hyperopia (farsightedness), astigmatism and presbyopia.

If a medical diagnosis is determined by your doctor, the patient's exam is no longer considered routine but medical and must be filed on your major medical insurance, any associated co-pays or deductibles will be collected at the time of the visit. Examples of medical diagnosis include; diabetes, hypertension, glaucoma, macular degeneration, cataract.

I authorize Vision Source Alexandria, L.L.C. to contact me by telephone or other media devices for communications needed to monitor my progress and to recommend care.

If your insurance company has not reimbursed our office in full within 60 days, you will be responsible for the balance and your insurance company will then reimburse you directly. Additionally, Vision Source Alexandria, L.L.C., reserves the right to charge an administrative and/or attorney fees incurred for the collection of delinquent accounts. There will be a service charge on all checks returned for any reason.

Patient Acknowledgement of Billing Policy

It is my responsibility (as a patient) to provide Vision Source Alexandria, L.L.C., all of my insurance information prior to my office visit. I have read and understand when my Vision Plan will be billed and when my Medical Insurance will be billed. I also understand that I am responsible for obtaining any and all referrals required by my insurance company for services performed by my doctor.

_____

Patient or Guardian Signature Relationship to Patient Date