VISION SOURCE®
Chambers Town Center

PATIENT CHECK-IN

Date _____ Appt Time _____

New Patient ____ Existing Patient ____

Last Name | First Name | MI | Date-of-Birth | Last 4 of SSN

Address | City, State | Zip Code | Male OR Female

Cell # | Alt # | Email

Vision Insurance | Primary/Subscriber Name | Member ID or SSN

ACTIVITIES (Check all that apply)

- ☐ Swimming
- ☐ Hunting
- ☐ Fishing
- ☐ Gardening
- ☐ Night driving
- ☐ Sewing/knitting
- ☐ Comp/phone/tablet ____ hrs/day
- ☐ Other _____

INTERESTED IN (Check all that apply)

- ☐ Laser vision correction
- ☐ Progressive lenses
- ☐ Thinner, lighter lenses
- ☐ Sports/safety goggles
- ☐ Computer glasses
- ☐ Sunglasses
- ☐ Transition lenses
- ☐ Other _____
- ☐ Contacts
- ☐ Contacts I can sleep in
- ☐ Colored contacts
- ☐ Multi-focal contacts

PERSONAL HISTORY (Check all that apply) ☐ **SAME AS LAST YEAR**

- ☐ Blurry vision
- ☐ Floater/Spots
- ☐ Crossed eyes
- ☐ Eye surgery
- ☐ Eye infections
- ☐ Dry eyes
- ☐ Tearing
- ☐ Cataracts
- ☐ Burning eyes
- ☐ Double vision
- ☐ Eye injury
- ☐ Lazy eyes
- ☐ Itchy eyes
- ☐ Blindness
- ☐ Glaucoma
- ☐ Arthritis
- ☐ Headaches
- ☐ Heart disease
- ☐ Light sensitivity
- ☐ Grittiness in eyes
- ☐ Thyroid
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Allergies
- ☐ Cholesterol
- ☐ Iritis/Uveitis
- ☐ Hypertension
- ☐ Smoking
- ☐ Other _____

FAMILY HISTORY (Check all that apply) ☐ **SAME AS LAST YEAR**

- ☐ Cancer
- ☐ Thyroid
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Blindness
- ☐ Cholesterol
- ☐ Hypertension
- ☐ Heart disease
- ☐ Iritis/Uveitis
- ☐ Macular degeneration
- ☐ Other _____

LIST CURRENT MEDICATIONS: _____

OFFICE USE ONLY (NOTES)

☐ Comp Exam	159
☐ Refraction	45
☐ Optos	50
☐ CL Fitting (Sphere)	99
☐ CL Fitting (Toric, MF,..)	109
☐ CL Fitting (Misight)	150

☐ Office Visit L1	80
☐ Office Visit L2	120
☐ Office Visit L3	160

- ☐ Order trials
- ☐ Order contacts
- ☐ Call to order contacts
- ☐ Follow-up required

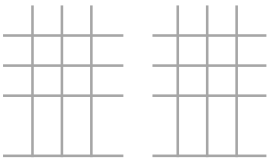
- ☐ Dr. Lai
- ☐ Dr. Crouch
- ☐ Other _____

PRELIMINARY TESTING

OD _____

OS _____

IOP _____ PD ____



PREVIOUS RX

OD _____

OS _____

PREVIOUS CONTACT RX

OD _____

OS _____

FINAL RX

OD _____

OS _____

FINAL CONTACT RX

OD _____

OS _____

VISION SOURCE®
Chambers Town Center

MATERIAL & SERVICE POLICY

		Initial
Cancellations	Patient may cancel their order and receive credit if we have not placed our order for materials. No refunds once materials have been ordered. No refunds should patient change their mind.	
Outside RX	If it is determined that an error was made in the prescription you received from another doctor's office, the error may be corrected once at no cost with an updated prescription from the other doctor. Additional remakes will be at full price.	
Non-adaptation	We cannot predict when patients will adapt to a new prescription. If you are unable to adapt, we will remake the lenses 1 time to correct the prescription so it may be worn.	
Contacts	Unopened contact boxes may be returned within 10 days of dispense for in-store credit. Credit may be applied towards new contacts or a pair of glasses. Patient must notify us within 5 working days of pick up with any issues with contacts so we may correct it. No Refund or Credit on orders after 14 days from date of purchase.	
Contact RX	My eye care professional will provide me with a copy of my contact lens prescription when it is finalized.	
Service Fees	Exam, contact lens fitting, office visit and follow-up fees are non-refundable. Contact fitting must be done within 30 days from date of eye exam.	
Fees	Fees are to be paid at the completion of the appointment. If your insurance company denies our claim, you are responsible for full payment.	
Communication	We will use the phone number(s) and/or email to communicate with you regarding your appointment and orders.	

Consent To Use or Disclose Health Information for Treatment, Payment & Health Care Operations

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 information in order to treat you, to obtain payment for our services and to conduct health care operations involving our offices.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosures of your health information may be necessary or appropriate in order 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 our submission of your health information to a billing agent or vendor for processing claims or benefits and payment or submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You may obtain an updated copy at the office or from our website.

When you sign this consent document, you signify that you agree that we may use and disclose your health information to treat you, to obtain payment for our services, and perform health care operations. You also signify that you have no other health or vision insurance (or that you have provided us with all insurance information) and agree that, since there is no guarantee of payment by an insurance company, you will be responsible for payment for services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent . We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the use or disclosures made for purposes of treatment, payment of health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, these restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

Signature _____ Date _____

Sign below if you are the Patient's Representative or Legal Guardian.

Representative or Legal Guardian _____ Relationship to patient _____ Date _____