VISION SOURCE®

MEADVILLE / TITUSVILLE

OIL CITY EYE ASSOCIATES

DR CHRISTOPHER L. ADSIT, OPTOMETRIST **DR. DUSTIN MITCHELL, OPTOMETRIST**
DR GARY HAWK, OPTOMETRIST

What brings you to our office today? _____

Full Name: _____ Date of Birth: _____

Address: _____

Employer: _____ Social Security # (For insurance purposes): _____

Who is your Primary Care Physician? _____

Do you have a family history of: **Glaucoma** YES NO **Macular Degeneration** YES NO

Are you willing to allow the doctor to dilate your eyes today? YES NO

Home Phone:_____ Cell Phone: _____

Work Phone: _____ Email: _____

How do you prefer to be contacted? Home Cell Work Email

May we text your cell phone for appointment reminders and order pick-ups? YES NO

May we use your email for contact lens ordering or general office communications? YES NO

Please check all that apply:

Race:

□ American Indian or Alaska Native

□ Asian

□ Black or African American

□ White

□ Other, Please Specify _____

Ethnicity:

□ Not Hispanic or Latino

□ Hispanic or Latino

At the doctor's request, if you have not already provided a printed list of medications, please write them down in the space provided below, or on the back of this form. The medications you take may affect your vision and knowing them will help your doctor diagnose conditions.

PAPERWORK CONTINUED ON BACK

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Acknowledgment of Notice of Privacy Practices

The law requires that Vision Source Meadville LLC make every effort to inform you of your rights related to your personal health information. The Notice of Privacy Practice is available in its entirety upon your request.

By my signing below, I acknowledge that:

___ I was given the opportunity to read, have read or had explained to me Vision Source Meadville LLC's Notice of Privacy Practice prior to any services offered.

___ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible.

Our offices may use standard email to communicate with you. Standard email is not secure and does not guarantee privacy.

___ I authorize the use of standard email, in spite of the known risk involved, to communicate with me.

___ I do not authorize the use of standard email to communicate with me.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient Name (print): _____

Patient Signature: _____ Date: _____

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

Representative Signature/Relationship to Patient: _____

CONTACT LENS PRESCRIPTION SIGNED ACKNOWLEDGEMENT FORM

I acknowledge that if I receive a contact lens exam, I am willing to receive my contact lens prescription electronically via my portal at RevolutionPHR. I also understand, If I do not want it electronically I can request a printed copy.

Signature:_____Date:_____

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CONSENT TO SHARE CONFIDENTIAL MEDICAL/VISION INFORMATION

Information concerning your care, condition, and orders is private. Information will only be provided through written consent provided by you (or your legal guardian), and will strictly be provided to those you have included on this form, or to health care professionals as needed for your treatment.

To be valid, this form must be filled out COMPLETELY.

Patient's Legal Name: _____ Date of Birth: _____

I hereby authorize Vision Source to share:

- □ Any information regarding my treatment
- □ Pick up orders – including glasses and/or contact lens supplies or trials

With the following people:

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

_____I do not wish to share any of my information.

I understand that I may cancel this consent at any time, but that canceling it will not affect any information that has already been released.

Signature:_____ Date:_____

If Patient is under 18, Relationship to minor: _____

PAPERWORK CONTINUED ON BACK

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OFFICE BILLING POLICY

In order to better serve you, we want to make you aware of our financial policy. ***Please read and sign prior to treatment.***

FINANCIAL POLICY

Payment for all co-pays and fees not billable to insurance are due at the time of service. Any additional balances required after claims are processed by your insurance will be billed to you and must be paid prior to future services being rendered. A 50% deposit is required on all eyewear and contact lens orders and the balance is due when eyewear and/or contacts lenses are dispensed. There is a $30.00 fee for any check returned by the bank. This fee will be added to the unpaid balance and must be paid by cash or credit card.

INSURANCE BILLING

As a courtesy to our patients, our offices agree to submit insurance claims to insurance carriers for which we are providers. Medical eye conditions will always be billed to your medical insurance. It is the undersigned's responsibility to understand his/her own insurance benefits and handle any and all insurance problems that arise. If you have insurance with which we are unfamiliar, or that we know from experience will not pay benefits directly to us, the undersigned will be responsible for fees for services rendered at the time of service. If you are insured through a managed health care program, we are obligated to follow your service contract regarding referrals to other specialists, even when that means a delay in your care. Due to insurance limitations, it may not be possible to obtain a referral from your primary care physician after you have already received treatment in our office. You may be responsible for the cost associated with services obtained without referral. It is your responsibility to verify authorization for care with your insurance company.

I authorize payment of insurance benefits directly to Vision Source Meadville LLC for professional services rendered. I authorize the release of my medical information to my insurance carrier(s) for the determination of benefits payable for services rendered and optical goods supplied by Vision Source Meadville LLC.

Patient Name (print): _____

Signature of Responsible Party (if not patient): _____

Patient Signature: _____ Date: _____