VISION SOURCE®
Chambers Town Center

CHECK-IN FORM

Date _____ Appt Time _____

New Patient ___ Existing Patient ___

Last Name | First Name | Middle Initial | Date-of-Birth

Address | Cell # | SSN

City, State Zip Code | Alt # | Male ☐ Female ☐

Purpose of visit today | Email

Vision Insurance | Medical Insurance

Subscriber Name | Subscriber Name

Member ID or SSN | Member ID or SSN

HOBBIES (Check all that apply)

- ☐ Swimming
- ☐ Hunting
- ☐ Fishing
- ☐ Gardening
- ☐ Night Driving
- ☐ Sowing/Knitting
- ☐ Activities/Indoors
- ☐ Activities/Outdoors
- ☐ Computer ____ Hrs/Day
- ☐ Other _____

INTERESTS (Check all that apply)

- ☐ Contacts I can sleep in
- ☐ Colored Contacts
- ☐ Multi-focal Contacts
- ☐ Laser Vision Correction
- ☐ Progressive Lenses/No-line Bi-focal
- ☐ Thinner, Lighter Lenses
- ☐ Computer Glasses
- ☐ Spare Pair Glasses
- ☐ Sports Goggles
- ☐ Sunglasses

PERSONAL HISTORY (Check all that apply. If Existing Patient and there is no change, check here ___ **No Change**)

- ☐ Blurry Vision
- ☐ Floater/Spots
- ☐ Crossed Eyes
- ☐ Eye Surgery
- ☐ Eye Infections
- ☐ Thyroid
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Dry Eyes
- ☐ Tearing
- ☐ Double Vision
- ☐ Light Sensitivity
- ☐ Heart Disease
- ☐ Burning Eyes
- ☐ Cataracts
- ☐ Allergies
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Eye Injury
- ☐ Headaches
- ☐ Cholesterol
- ☐ Heart Disease
- ☐ Itchy Eyes
- ☐ Lazy Eye
- ☐ Blindness
- ☐ Grittiness in Eyes
- ☐ Iritis/Uveitis
- ☐ Hypertension
- ☐ Other _____

FAMILY HISTORY (Check all that apply. If Existing Patient and there is no change, check here ___ **No Change**)

- ☐ Cancer
- ☐ Allergies
- ☐ Thyroid
- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Smoking
- ☐ Glaucoma
- ☐ Contacts
- ☐ Blindness
- ☐ Cholesterol
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Iritis/Uveitis
- ☐ Macular Degeneration
- ☐ Other _____

LIST CURRENT MEDICATIONS: _____

OFFICE USE ONLY

PAIR #1

- ☐ Single Vision
- ☐ Flat Top
- ☐ Progressive
- ☐ Plastic
- ☐ Poly
- ☐ Hi-Index
- ☐ Anti-glare
- ☐ Transitions
- ☐ Tint/Polarized

PAIR #2

- ☐ Single Vision
- ☐ Flat Top
- ☐ Progressive
- ☐ Plastic
- ☐ Poly
- ☐ Hi-Index
- ☐ Anti-glare
- ☐ Transitions
- ☐ Tint/Polarized

EXAM	OPTOS	CONTACT LENS		OPTICAL MATERIALS		TOTAL	FEES PD	BALANCE
		FITTING	CL	FRAME	LENSES			

VISION SOURCE®

Chambers Town Center

MATERIAL & SERVICE POLICY

		Initial
Cancellation	Patient may cancel their order and receive credit only if we have not placed our order for materials. If materials have been ordered, patient may receive refund less a 20% restocking fee.	
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 one time at no cost. 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 2 times to correct the prescription so it may be worn.	
Contacts	Unopened contact boxes may be returned within 14 days of dispense for credit. The amount may be applied towards new contacts or a pair of glasses. **No Refund or Credit will be given for contacts after 14 days from date of dispense.**	
Service Fees	Exam, contact lens fitting, office visit and follow-up fees are non-refundable.	
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.	

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 _____ Dated _____

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

Signature _____ Relationship to Patient _____ Dated _____

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