VISION SOURCE™
FAMILY EYE CARE

WELCOME TO OUR OFFICE

From the Doctors and Staff of Vision Source

Name: _____ Date: _____
(Last) (First) (Middle Initial)

Sex: ☐ Male ☐ Female Date of Birth: _____ SSN: _____ ☐ Single ☐ Married ☐ Other

Daytime Phone #: _____ Mobile Phone #: _____ E-Mail: _____

Mailing Address: _____
(Street) (City) (State) (Zip Code)

Employer/School: _____ Occupation/Grade: _____

Employer/School Phone #: _____ Emergency Contact Person: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Parent ☐ Other Name of Insured: _____
(If Primary Insurance Holder is another person; i.e. Patent, Legal Guardian or Spouse. See your insurance card)

Insured's Address: _____
(Primary Insurance Holder, If Different) (Street) (City) (State) (Zip Code)

Insured's Date of Birth: _____ Insured's SSN: _____ Insured's Phone #: _____
(Primary Insurance Holder) (Primary Insurance Holder) (Primary Insurance Holder)

Health Insurance Company: _____ Vision Insurance Company: _____

Our front desk needs a copy of your Driver's License and ALL current Medical / Health and Vision Insurance cards.
Without providing our office with this information TODAY, the insured will be responsible for all charges.

How will you settle your account today? ☐ **Cash** ☐ **Check** ☐ **Credit Card**

Do you participate in a medical flex account? ☐ **Yes** ☐ **No**

Personal Ocular and Medical History

	NO	YES	?		NO	YES	?
Loss of Vision	☐	☐	☐	Blurred Vision at Distance or Near	☐	☐	☐
Distorted Vision / Halos	☐	☐	☐	Loss of Side Vision / Glaucoma	☐	☐	☐
Double Vision	☐	☐	☐	Dry Eyes	☐	☐	☐
Lazy Eye / Crossed Eyes	☐	☐	☐	Red Eyes	☐	☐	☐
Sandy / Gritty Feeling	☐	☐	☐	Itching Eyes	☐	☐	☐
Burning Eyes	☐	☐	☐	Foreign Body Sensation	☐	☐	☐
Excessive Tearing / Watering Eyes	☐	☐	☐	Glare / Light Sensitivity / Cataracts	☐	☐	☐
Eye Pain / Soreness	☐	☐	☐	Chronic Infection / Sty of Eye or Lid	☐	☐	☐
Macular Degeneration	☐	☐	☐	Flashes / Floaters in Vision	☐	☐	☐
Eye Strain / Tired Eyes	☐	☐	☐	Diabetes	☐	☐	☐
Eye Surgery	☐	☐	☐	Ocular / Retinal Disease	☐	☐	☐
Retinal Detachment	☐	☐	☐	Heart Disease	☐	☐	☐

List all medications and the reason you are taking them: _____

_____

_____

_____

Female patients: Are you presently taking hormone replacement or birth control? ☐ No ☐ Yes Are you **pregnant** or lactating (nursing)? ☐ No ☐ Yes

Do you have any allergies to medications? ☐ No ☐ Yes, if so, what medications: _____

_____

_____

Do you wear glasses? ☐ No ☐ Yes

Do you currently wear contact lenses? ☐ No ☐ Yes

If so, what type? _____

Contact Lens Solution Used: _____

Would you prefer clear or colored contact lenses (to change eye color)? _____

If you wear bifocals, are the lines or your head tilt bothering you? ☐ No ☐ Yes

Do You…… (Check all that currently apply)

☐…Work at a computer?

☐ …Think you might benefit from a thinner, lighter lens?

☐ …Have an interest in "Test Driving" one of the latest contact lens designs?

☐…Spend time outdoors? (How hours / week: _____)

☐ …Have prescription sunglasses?

☐ …Prefer not to wear you glasses at certain times?

☐…Want information on Laser Corrective surgery?

☐…Have more than one (1) pair of current prescription glasses?

☐ …Have children?

☐ …Have family members in need of eye care?

Personal Social History

Do you smoke or use tobacco? ☐ No ☐ Yes, if so, how much per day: _____

Do you drink alcohol? ☐ No ☐ Yes, if so, how much and how often: _____

Do you use illegal drugs? ☐ No ☐ Yes, if so, what type, how much and how often: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV / AIDS ☐ Syphilis

Family Medical History

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

Disease / Condition	No	Yes	?	Relationship to the Patient
Blindness	☐	☐	☐	
Cataract	☐	☐	☐	
Crossed Eyes	☐	☐	☐	
Glaucoma	☐	☐	☐	
Age Related Macular Degeneration	☐	☐	☐	
Retinal Detachment / Disease	☐	☐	☐	
Arthritis	☐	☐	☐	
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lupus	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Auto-Immune Disease	☐	☐	☐	
Other: _____				

EyeScape® Retina Digital Imaging System Consent

In our continued efforts to bring the most advanced technology available to our patients, Vision Source – Family Eye Care is proud to announce the inclusion of the EyeScape® Retina Digital Imagining System. The **EyeScape® Retina Digital Imaging System** is considered to be the most technologically advanced procedure for evaluating your internal eye health. This procedure is the best way to detect eye diseases including: **cataracts, glaucoma, macular degeneration, retinal holes or detachments, and systemic disease such as diabetes, stroke, and high blood pressure. All of these conditions can lead to serious systemic or ocular health problems, including partial loss of vision and blindness. These conditions can develop without any signs or symptoms.** The EyeScape® Retina Digital Imaging System provides an internal digital image of your eye including an in-depth view of your retinal layers (where disease begins) for both you and your Doctor to review. Also, your image will become part of your permanent medical file, allowing your Doctor to evaluate, diagnose, and track retinal change/disease throughout your lifetime.

The EyeScape® Retina Imaging System is fast, easy and comfortable. It can actually SHORTEN the length of your eye health exam up to 45 minutes. The reason: dilation of the eye is NOT needed for this test, thus, saving a minimum of 6 to 8 hours of blurred vision.

The Doctors of Vision Source – Family Eye Care recommend the EyeScape® Retina Digital Imaging System for all of their patients. Unfortunately, most insurance companies do not cover any advanced eye care technology. Therefore, we will perform the EyeScape® Retina Digital Image System retinal examination as an enhancement to your general eye health examination for a **fee of $35.00**.

Please check one of the following:

☐ **Yes**, I would like my eye health examination to include the **EyeScape® Retina Digital Imaging System.**

☐ **No**, I would like to **decline** the **EyeScape® Retina Digital Imaging System**, and I wish to have my eyes **dilated**.

_____ _____

VISION SOURCE™
FAMILY EYE CARE

Dr. Ian Buchli
Dr. Scott Trefts
Board Certified Optometric Physicians

Marketing Survey

1. Where did you hear about our practice? _____

2. Where else have you heard of our practice?

☐ Internet ☐ Newspaper ☐ Billboard ☐ Yellow Pages

☐ Television ☐ Insurance Carrier ☐ Local Magazine ☐ Radio

☐ Friend: _____
(Please let us know who we need to thank for their referral)

☐ Other: _____

90 Village at Glynn Place,Brunswick, GA 31525
(912) 264-6000 Telephone (912) 264-0808 Fax

775 C Kingsbay Road, St Marys GA 31558
(912) 729-6111 Telephone (912) 729-8595 Fax

125 West Cherry Street, Jesup GA 31545
(912) 427-7773 Telephone (912) 427-7130 Fax

Vision Source Family Eye Care's Financial Policy and Agreement

Vision Source Family Eye Care is dedicated to providing the best possible patient care and we want you to completely understand our financial policies.

Patients with Insurance

If you have insurance, we will gladly file your claim. **Your deductible and co-pay is expected at the time of service.** We can only estimate the amount you owe, which is based on the information **your insurance carrier** provides us. If your insurance carrier pays less than their estimated portion, you will be responsible for the remaining balance upon receiving your bill. Insurance claims outstanding 30 days or more will become your responsibility to pay.

In the event our Doctors discover an issue resulting in a medical diagnosis, your eye health examination **MUST** be billed through **your medical health policy, not vision**. This is a billing directive from all vision insurance companies.

Patients without Insurance

Full payment is expected on the day of service.

Payment Options

We accept Gold, US or Euros as currency, corporate or personal checks, money orders, credit cards (American Express, Visa, Master Card, and Discover), and the Vision Source Affordability Program by Care Credit.

Broken Appointments

We reserve the right to charge $50.00 for appointments cancelled or broken without 24 hours notice prior to the appointment time/date. This charge must be paid before another appointment can be scheduled. Arriving 15 minutes or more after your scheduled appointment could result in rescheduling your appointment and a broken appointment charge.

Returned Checks

Returned checks will be subject to a $30.00 service fee and charges for any bank fees, which must be paid in cash along with the amount of the check within 10 days or it will be turned over to collections.

Statement of Services

Statement of Services is due upon receipt. We consider an account delinquent after 30 days and may be **assessed a $5.00 per week service charge**. Accounts 60 days past due are transferred to collection status. We reserve the right to use outside sources to collect on any past due accounts. You will be responsible for all costs, including attorney fees, court fees, **$100.00 administrative fee**, etc.

Eyewear Not Picked Up within 90 Days / Cancelled Orders

Any material (glasses or contact lenses) not picked-up ninety (90) days from the original order date will be donated by Vision Source Family Eye Care to our local Lion's Club for people in need of eyewear. The deposit for such material will then be forfeited and is deemed non-refundable. Any cancelled orders will be refunded less a restocking fee of fifty (50) percent of the total eyewear fee billed.

Authorization for the release of Information

The signature below serves as a *Lifetime Signature Authorization* for Vision Source Family Eye Care to release or receive medical information for the purpose of patient referral, treatment, billing, and/or benefits payable for related services. It is to be understood that these requests will be handled in accordance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and all updated provisions of the act. A copy of this signature is as valid as the original. I, the undersigned, have read and agree to be bound by the financial policy's terms stated in the paragraphs above and accept full financial responsibility for the fees charged. I also understand and agree that such terms may be amended.

Please print the name of the patient: _____

_____ Date: _____

Signature of patient (or responsible party, if patient is a minor or has a legal guardian)