VISION SOURCE™

MEADVILLE

DR. CHRISTOPHER L. ADSIT, OPTOMETRIST
DR. SCOTT A. KENNEDY, OPTOMETRIST
DR. DUSTIN J. MITCHELL, OPTOMETRIST
DR. JENNY L. TRAN, OPTOMETRIST

First Name:_____ Last Name:_____

Please check all that apply:

Race

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other

Ethnicity

☐ Not Hispanic or Latino
☐ Hispanic or Latino

Communication Preferences:

☐ HOME ☐ CELL ☐ TEXT ☐ EMAIL ☐ WORK

Primary Care Physician:_____

Home:_____

Work:_____

Cell:_____

Address:_____

Email:_____

Reason for Visit:_____

If you have a list of medication please provide with this paper.

1073 S MAIN ST MEADVILLE, PA 16335 TEL: 814-333-6606 FAX: 814-333-6616

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CONSENT TO SHARE CONFIDENTIAL MEDICAL/VISION INFORMATION

To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient's Legal Name: _____

DOB:_____

I hereby authorize Vision Source to share:

- ☐ Any information regarding my treatment as a patient here
- ☐ 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:_____

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.

This authorization expires: ☐ **When I cancel it in writing** ☐ **Date:**_____

Signature:_____**Date:**_____

Relationship to minor patient:_____

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OFFICE POLICY

Thank you for choosing us as your healthcare provider. We are committed to the success of your vision treatment. In order to better serve you, we want to make you aware of your financial policy and payment options. ***Please read and sign prior to treatment.***

FINANCIAL POLICY

Payment for all services is expected at the time of service; except for those covered by your insurance policy. 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. All co-pays and contact lens fitting fees, when applicable, are due at the time of service.

There is a $25.00 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 of our patients, Vision Source Meadville agrees to submit a claim, on behalf of the patient, to insurance carriers for which we are providers. It is the undersigned's responsibility to handle any and all problems that arise with your insurance company, not with this office. We will assist in providing information, but it is the responsibility of the undersigned to know their insurance and benefits.

I authorize payment of insurance benefits directly to Vision Source Meadville for professional services rendered. I authorize the release of medical information about me to my insurance carrier(s) for the determination of benefits payable for services rendered and optical goods supplied by Vision Source Meadville. 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 your insurance is through a managed health care program, we are obligated to follow your service contract regarding referrals to other specialist, 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.

Patients Name (print):_____

Patients Signature: _____Date:_____

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Vision Source Meadville provide this consent to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept safe.

This is summary of and consent for the privacy practice and patient care at Vision Source Meadville and services as a condensed version of our Notice of Privacy Practices. You have the right to review our notice before signing this consent upon request. The terms of our notice may change and you may obtain a revised copy by contacting our office.

The patient understand that:

- Protected health information may be disclosed or used for treatment, payment or health care operation
- The practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the use of their information but the practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all further disclosure will then cease
- The practice may condition treatment upon execution of this consent

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we already have made in reliance on your prior consent. Vision Source Meadville may condition treatment upon the execution of this consent.

Additionally, by signing this form, you acknowledge that by presenting yourself or child as a patient you consent for vision and medical eye care by the doctors and staff of Vision Source Meadville. You hereby grant full authority to the optometrists/ophthalmologist, and their respective assistant to administer and perform any and all drugs, treatments, test, or diagnostic procedures to or upon me, which may be advised, or necessary.

Patient Name (print):_____

Responsible Party (if not patient):_____

Signature of Patient:_____Date:_____

Medical History Questionnaire

Today's Date: ____/____/____

Full Name:_____ Birth Date:____/____/____

Title: Mr. Mrs. Miss. Dr. Other Marital Status: Single Married Widowed Divorced Separated

Address:_____ Social Security #:_____

_____ Home Phone: _____

Responsible Party if different:_____ ***Billing Address if different***:_____

Phone:_____ ***Relationship to patient***:_____

Medical Insurance:_____ Vision Insurance:_____

Place of Employment:_____ Work Phone:_____

If Married, Name of Spouse:_____ Spouse's place of work:_____

Name of Medical Doctor:_____ Last Medical Exam:____/____/____

Name of Previous Eye Doctor:_____ Last Eye Exam:__/____/____

Who May we thank for referring you to our office:_____

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED

A Fifty Percent (50%) deposit on all contact lenses and glasses is required before an order can be placed. The balance must be paid before materials are dispensed. **We accept Visa, MasterCard, Discover, and Debit Cards.**

Ocular/Medical History

Do you wear glasses? No Yes If yes, how old is your current pair of lenses?_____

Do you wear contact lenses? No Yes If yes, what type? RGP Soft Do you sleep in them? No Yes

How frequently do you replace them?_____ Are they comfortable? No Yes

Have YOU ever been diagnosed with any of the following eye conditions?

Cataract	No Yes	Infection, Inflammation, or allergy	No Yes
Macular Degeneration	No Yes	Floaters and/or Flashes of light	No Yes
Glaucoma	No Yes	Iritis or Uveitis	No Yes
Diabetes	No Yes	Retinal Defects or Degenerations	No Yes
Diabetic Retinopathy	No Yes	Other (Please Specify):_____	
Dry Eye	No Yes	_____	

Are YOU having any of the following eye concerns?

Redness	No Yes	Discharge	No Yes
Burning	No Yes	Other (Please Specify):_____	
Itching	No Yes	_____	
Tearing	No Yes		

Are YOU having any of the following vision concerns?

Blurred Vision	No Yes	Bothersome Night Glare	No Yes
Eye Strain	No Yes	Double Vision	No Yes
Eye Pain	No Yes	Total Loss of Vision	No Yes
Severe Sensitivity to Lights	No Yes	Other (Please Specify):_____	
Headache	No Yes	_____	
Poor Night Vision	No Yes		

Review of Systems (Please Circle any problem you currently have, or had in the past)

Constitution
All Normal
Developmental Disabilities
Cancer
Fatigue Syndrome
Other_____

Ears, Nose, Throat, Mouth
All Normal
Hearing Loss
Sinusitis
Dry Mouth
Laryngitis
Other_____

Neurological
All Normal
Multiple Sclerosis
Epilepsy
Cerebral Palsy
Tumor
Stroke/CVA
Migraine
Autism Spectrum Disorder
Other_____

Psychiatric
All Normal
Depression
Attention Deficit
Anxiety Disorder
Bipolar Disorder
Other_____

Cardiovascular
All Normal
High Blood Pressure
Stroke/CVA
Heart Disease
Vascular Disease
Congestive Heart Failure
Other_____

Respiratory
All Normal
Cigarette Smoker
Asthma
Bronchitis
Emphysema
Chronic Obstruction
Sleep Apnea
Other_____

Gastrointestinal
All Normal
Crohn's
Colitis
Ulcer
Acid Reflux
Celiac Disease
Other_____

Genitourinary
All Normal
Kidney Disease
Prostate Disease/Cancer
STD – Herpetic/Chlamydia
Benign Prostrate Hypertrophy
Pregnant
Nursing
Other_____

Musculoskeletal
All Normal
Osteoarthritis
Arthritis
Fibromyalgia
Muscular Dystrophy
Ankylosing Spondylitis
Osteoporosis
Gout
Other_____

Integumentary (Skin)
All Normal
Eczema
Rosacea
Psoriasis
Herpes Simplex (Cold Sores)
Herpes Zoster (Shingles)
Other_____

Endocrine
All Normal
Type 2 Diabetes
Type 1 Diabetes
Thyroid Dysfunction
Hormonal Dysfunction
Other_____

Hemotologic/Lymphatic
All Normal
Anemia
Large Volume Blood Loss
Ulcer
High Cholesterol
Other_____

Allergic/Immune
All Normal
Drug Allergies
Environmental Allergies
Rheumatoid Arthritis
Lupus
Sjogren's Syndrome

Surgeries/Other Medical problems:_____

Please list your current medications (Include oral contraceptives, over the counter medications, and home remedies):_____

_____

_____

Are you allergic to any medications? No Yes If yes, please explain:_____

_____

Are you sensitive to latex? No Yes Other Allergies?_____

Past Eye History (Please Circle any problem you currently have, or have had in the past)

All Normal	Surgery	Retinal Degeneration	Dry Eye
Glaucoma	Patching	Retinal Hole	Nystagmus
Glaucoma Suspect	Inflammatory Disorder	Retinal Detatchment	Other_____
Cataract	Strabismus (Eye Turn)	Keratoconus	_____
Macular Degeneration	Amblyopia (Lazy Eye)	Injury	

Social History (Strictly confidential, If you wish, you may leave blank and discuss this directly with your doctor)

Alcohol Use: No Yes If yes, how often?_____
Current Tobacco Use: No Yes If yes, what type?_____
Have you ever used tobacco? No Yes If yes, what type?_____

Family Medical History (Please circle if your immediately family have any of the following)

Cancer	Dad	Mom	Brother	Sister	Son	Daughter	Unknown	None
Diabetes Type 1	Dad	Mom	Brother	Sister	Son	Daughter	Unknown	None
Diabetes Type 2	Dad	Mom	Brother	Sister	Son	Daughter	Unknown	None
High Blood Pressure	Dad	Mom	Brother	Sister	Son	Daughter	Unknown	None
Hyperthyroidism	Dad	Mom	Brother	Sister	Son	Daughter	Unknown	None
Hypothyroidism	Dad	Mom	Brother	Sister	Son	Daughter	Unknown	None
Family Ocular History								
Cataract	Dad	Mom	Brother	Sister	Son	Daughter	Unknown	None
Macular Degeneration	Dad	Mom	Brother	Sister	Son	Daughter	Unknown	None
Glaucoma	Dad	Mom	Brother	Sister	Son	Daughter	Unknown	None

Signature:_____ Date: _____/_____/_____