Vision Source Winder - Visit Information

Pt #_____

Full Name_____ Date of birth_____ Social Security #_____-____-_____

Address_____ City_____ Zip Code_____

Email_____ Employer_____

Home Phone_____ Cell _____ Marital Status S M W D

Primary physician_____

Medications *Enter all medications taken, and for which condition each is taken*

Medication **Condition**

_____

_____

_____

_____

_____

_____

_____

Allergies *Enter all medications or substances to which the patient is allergic*

_____

Eye Health *Check all that apply*

__Amblyopia

__Blurred Vision- Far or near

__Burning Eyes

__Cataracts

__Double/Distorted Vision

__Drooping Eyelid

__Dry Eyes

__Eye Surgeries

__Floaters/Spots

__Fluctuating Vision

__Foreign Body Sensation

__Glaucoma

__Glare/Light Sensitivity

__Headaches

__Itchy Feeling

__Mucus/Discharge

__Redness

__Retinal Detachment

__Teary/Watery Eyes

Do you smoke tobacco products? __Yes, I smoke every day __Yes, I smoke occasionally __No, I'm a former smoker __No, I've never been a smoker

Are you pregnant or nursing? __Yes __No

Do you wear glasses? __Yes __No

Do you have trouble driving at night? __Yes __No

Do you wear contacts? __Yes __No

VISION SOURCE™ Winder
Winder Eye Care Center
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Winder, GA 30680
Phone: 770.867.2505 FAX: 770.867.8668
Email: Vswfrontdesk@gmail.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES VISION SOURCE WINDER

As provisioned by the *Health Insurance Portability and Accountability Act of 1996* we must provide you with a detailed notice, in writing, of our privacy practices. By signing this notice you have acknowledged receipt of our 'Notice of Privacy Practices'. If you would like a copy of our Notice of Privacy Practices to take with you, please let one of our associates know.

If you would like to authorize another individual or facility to access your medical records from Vision Source Winder, please list them below. Any persons listed below may have access to the following protected health information: prescriptions, office visit notes, financial information, personal information, and/or picking up products.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I, _____, hereby acknowledge receipt of the *Notice of Privacy Practices Policy of Vision Source Winder.* By signing this form, I authorize Vision Source Winder to obtain medical and prescription information from outside sources and to release medical information necessary to process my claims, including information for any healthcare related utilization or quality assurance activities without my additional consent.

_____

Patient or Parent/Guardian Signature

_____

Date

This acknowledgement page should be retained in the patient's record.
If an acknowledgement could not be obtained from the patient, note the reasons below.

_____

_____

Vision Source™ Winder - Financial Policy

It is the policy of Vision Source Winder that **payment is due at the time of service** unless other financial arrangements are made in advance. We require all patients to pay their deductible, co-pay and/or coinsurance at each visit. Cash, check, debit card, MasterCard, Visa, Discover, American Express, as well as Care Credit are acceptable forms of payment. A credit card is required for all on-line and telephone orders.

A $35.00 'non-sufficient fund' fee will be added for all returned checks. Any account not paid in full within sixty days will automatically have a 1.5% per month service charge (18% per annum) added. Should your account be turned over for collection, you will also be responsible for any costs incurred, including a $40 collection fee added to the balance.

If there is any money owed back to you, *Vision Source Winder will issue a refund once all balances associated with the account are cleared*. This includes any amount still outstanding with you, your insurance company, and/or products ordered. All refunds are subject to review and may take up to 30 days to reflect on your credit card statement or receive via check. All refunds must be issued back to the Guarantor and/or Insurance policy holder unless there are specific circumstances preventing this to be performed. **All returns are subjected to a restocking fee of 25%**. All returned contact lens must be in original, unopened packaging. If the package is opened, written on or damaged, we will not be able to accept the product and the return will be denied.

All patients wearing contact lenses receive tests and follow-up care above and beyond a comprehensive exam. This is referred to as a "Contact Lens Medical Evaluation" and is performed on all patients wearing contact lenses every 12 months whether or not new contact lenses are purchased. There is an additional charge for this service. Most insurance plans do not cover contact lens related charges.

Insurance Information:

-We are currently **participating providers** with the following insurance companies:

Medical Companies:
AARP
Aetna
Assurant Health
Blue Cross Blue Shield (most plans)
Care Improvement Plus
Carpenters Local 713
Cigna
Cigna HealthSprings
GEHA
Humana
IBEW
Medicare (most Medicare supplemental plans)
Teamsters/Central States
United HealthCare
United HealthCare Medicare Advantage
United HealthCare River Valley Plus

Vision Companies:
Blue View Vision (EyeMed)
Cigna Vision (VSP)
EyeMed (most plans)
Humana Vision (Vision Care Plan)
United Health Care Vision
Vision Service Plan (VSP)

*Please be aware: We are **NOT** automatically in network with your vision plan just because we are in network with your medical plan. Please see an associate if you have any questions regarding your insurance coverage.

We file your insurance as a courtesy to you. Because of the many plans available, even under the same carrier, it is impossible for us to know what your exact coverage is. It is therefore your responsibility to provide proof of insurance at the time of check-in and to be aware of your coverage. If the correct insurance is not provided at the time of service, it will become your responsibility to file for reimbursement through your insurance company. PROVIDING INSURANCE INFORMATION DOES NOT GUARANTEE COVERAGE AND ULTIMATELY, YOU ARE FINANCIALLY RESPONSIBLE FOR THE SERVICES RENDERED AND PRODUCT RECEIVED AT THE TIME OF SERVICE. You agree, in order for us to service your account to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Thank you for your understanding and for your cooperation regarding our financial policy. We hope this financial simplification will allow us to continue to provide the ultimate in eye health and vision care to you and your family.

I have read and understand the above financial policy. I realize that the final responsibility for payment of fees lies with me, the patient and/or parent/guardian. I also authorize payment of benefits to Vision Source Winder if agreed upon at the time of service. I agree that this office and/or a collection agency may contact me/us as described above.

Patient Name	Patient Signature	Date
Parent/Guardian Name *(if patient is a minor)*	Parent/Guardian Signature	Date