Date: _____

Patient Information Form

GENERAL INFORMATION

Name (First, MI, Last) _____ Preferred Name: _____

Street Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Email Address _____

Preferred Contact Method: cell phone / email / text / home phone / other (please explain) _____

Date of Birth_____ Male / Female Language, Race, Ethnicity _____

Employer (or School)_____ Occupation (or Grade)_____

Emergency Contact Person and Phone _____

If you are a new patient, how did you hear about us?_____

Do you currently wear glasses? Yes / No Do you currently wear contact lenses? Yes (Brand_____) / No

Name of primary physician_____

Pharmacy _____ Are you pregnant or nursing? _____

CONSENT TO TREATMENT

I hereby grant MY authorization and consent for medical treatment and procedures for myself and/or minor children and certify that no guarantee or assurance has been made as to the results which may be obtained. I authorize the eye doctor to release information (including diagnosis and treatment) rendered to me or my child to third party payers and/or health practitioners. I authorize the eye doctor to obtain and view my medication history via electronic database or from my pharmacy or doctor's office. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____	_____	_____
Signature of patient or Guarantor	**Relationship if not patient**	**Date**

Vision Source of Rainbow City

CHECK IN FORM

*****PLEASE READ CAREFULLY AND SIGN BELOW*****

Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge I have been presented a copy of the Notice of Privacy Practices. I know that at any time I can request my own personal copy of the form. _____ (initials)

****

No-Show and Late Cancellation Policy:

We understand there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from being seen. Just as if another patient fails to cancel an appointment, we may be unable to schedule you for a visit due to a seemingly "full" schedule. *Therefore, if a 48-hour cancellation notice is not given, you will be charged a no-show/late cancellation fee of* **$35.00**. *This fee is not covered by your insurance.*

Patients who habitually no show or reschedule (more than 3 consecutive times) may be required to provide a credit card to hold future appointments. A **$35.00** fee will be charged to this card for any future missed appointments.

****

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, authorize *Vision Source of Rainbow City*, doctors and staff; to disclose information regarding my medical treatment and diagnosis and information regarding my financial account with the following designated individuals or organizations: _____

Name of person(s) you authorize release of information to (i.e. another doctor's office, a family member)

***You may revoke this right at any time.**

****

Optomap Digital Retinal Imaging

As part of your exam today, our technician will perform the *Optomap* imaging, which the doctor will then review with you. This quick, non-invasive imaging scan can help detect vision threatening and systemic diseases in their very early stages, when they are most treatable. There is a **$34.00** charge for this service, which is not covered by insurance.

****

Insurance/Billing Policy

Please provide both your **vision plan** information as well as your **major medical insurance information**. All of our patients will receive a **COMPLETE EYE HEALTH EXAMINATION**. Our doctor is trained to diagnose and treat most ocular diseases.

As a courtesy to our patients, we are happy to file with your insurance company. NOTE: The patient is responsible for any co-pays and / or deductibles which your insurance requires. ALL examination fees are *non-refundable* and must be paid on the day services are rendered.

Routine Vision exams will be filed with a patient's Vision Plan if you have one. A routine exam means there is not a medical diagnosis. Routine diagnosis is myopia (near-sightedness), hyperopia (farsightedness), astigmatism, and presbyopia.

If a ***Medical Diagnosis*** (cataracts, glaucoma suspect, glaucoma, diabetes, pink eye-conjunctivitis, foreign body, etc.) is determined by the doctor the patient's exam is no longer routine, but medical. This means we will bill your Health (Medical) Insurance. We request a copy of your medical card in your chart for these reasons. The refraction (determination of glasses prescription) is not covered by medical insurance. The patient is responsible for payment of non-covered services, including the refraction fee of $30.00.

I have read and understand when my ***Vision Plan*** *will be billed and when my* ***Medical Insurance*** *will be billed.*

****

I, _____, have read and understand *all* of the above information.

(Print your name)

_____	_____	_____
Signature of patient (or guarantor)	**Relationship if not patient**	**Date**

Vision Source of Rainbow City
OPTICAL POLICIES
PLEASE READ CAREFULLY AND SIGN BELOW

Return/Remake Policy

We will start your custom eyeglasses order immediately after payment! For this reason, *cancellations on eyeglasses are not permitted*. All glasses are custom crafted for each patient with their unique prescription. Also, all eyeglass lenses are custom cut to fit the frame each patient has selected. Therefore, patients may not switch frames after their lenses have been cut. For all of these reasons, *cash refunds are not possible*. Patients who are not satisfied with the vision in their new glasses may schedule a prescription check with the doctor. If an adjustment in prescription is necessary, lenses will be remade at no cost, **within 45 days** of the original purchase date. Although refunds are not available on progressive lenses, any patient who fails to adapt to their new progressives will have their prescription remade one time into a lens type of their choice at no additional charge.

If patient preference requires subsequent remakes the patient will be charged an additional fee for the cost of the change. If a patient decides to upgrade or change the type of lenses and/or frame after initial purchase there will be an additional charge for the lenses/frames.

Warranty

All frames have at least a one-year manufacturer's warranty from the date of purchase unless it was purchased as a discontinued or discounted frame. If the frame breaks or has a manufacture's defect, the frame or part will be replaced. This warranty does not cover accidental damage, scratches, or breakage due to misuse.

Lenses also have at least a one-year manufacturer's warranty.

Payment of at least half of the balance is required at the time of order. Spectacles will not be dispensed to the patient until the balance is paid in full. Vision Source of RBC is not responsible for eye wear that is not picked up within 60 days of purchase. If a refund is deemed necessary by the doctor, the amount refunded will be at a rate of 50% of the purchase amount in the form of check or credit back to the credit card used for purchase. Refunds will take place within 60 days of request.

Use of Personal Hardware (Frames/Lenses)

There is no warranty provided for patient supplied materials. If a patient chooses to supply their own spectacle frame for use, neither Dr. King's office and any labs used by Dr. King's office will NOT be responsible for any repair necessary or any damage, including breakage that may occur to these items. *Patients using their own frames do so at their own risk.*

****

I, _____, **have read and understand all of the above office policy information.**

(Print name)

_____	_____	_____
Signature of patient or Guarantor	**Relationship if not patient**	**Date**

CONTACT LENS POLICY

THIS DOCUMENT IS TO ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND, AND AGREE TO THE FOLLOWING POLICY:

* I must have a comprehensive eye exam, including dilation if deemed necessary by the doctor, before being fit with contact lenses.

* If a contact lens fitting is performed at a later date than my comprehensive eye exam, the contact lens prescription released will be back-dated to the last exam date and will expire one year *from the exam date*.

* The fitting fee includes all necessary follow-up visits within a 45-day period. After 45 days, all professional services will be billed at the usual and customary fees.

* The fitting fee does *not* include the cost of the prescribed contact lenses.

**** The contact lens prescription will only be released after the initial fitting period is completed and all fees are paid.***

* The initial fitting period may not be deemed complete until *after all necessary follow-up visits are completed*. One or more follow-up visits may be necessary to ensure a proper fit.

* Patients that are unable to complete the fitting process (cannot get contacts in or out on their own, give up, etc.) will still be charged the fitting fee, discounted by 50%.

Contact lenses are prescribed medical devices.

As with any drug or medical device, the use of contact lenses in not without risk. A small percentage of individuals wearing contact lenses develop potentially serious complications which can lead to permanent eye damage.

If you experience any unexplained: Eye pain, watering or discharge, decrease in vision, or increased sensitivity to light, remove your contact lenses and call our office to be seen by the doctor before wearing you contact lenses again.

Fitting Children in Contact Lenses:

* *We will **NOT** fit any child in contact lenses that do not wish to wear them*. If it is discovered that the child does not want to be fit and the parent is making their child be fit, the fitting process will be immediately stopped. You will still be charged the fitting fee, discounted 50%.

* Parents will not be allowed in the contact lens room while their child is being trained on insertion and removal of contact lenses.

Return policy:

All contact lenses can be returned within 30 days of the order date and a refund granted as long as the *packages are unopened.*

All non-specialty contacts have a 30-day warranty from the order date. If a patient is not satisfied with their new contacts, a contact lens check may be scheduled with the doctor and we will exchange any unopened contact lenses packages at no charge within the 30-day period.

Specialty contact lenses including gas permeable, keratoconus lenses, hybrids, or scleral lenses have a 90-day return/exchange policy.

I acknowledge that I have read and fully understand the terms of this agreement.

Signature Date