VISION SOURCE™

MEADVILLE

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

First Name:_____Last Name:_____

Please check all that apply:

Medications list:

Race

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

Ethnicity

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Do you have a family history of:

Macular Degeneration ☐ YES ☐ NO

Glaucoma ☐ YES ☐ NO

Are you willing to let the Doctor dilate you today? ☐ YES ☐ NO

Communication Preferences:

☐ HOME ☐ CELL ☐ TEXT ☐ EMAIL ☐ WORK

Home:_____

Work:_____

Cell:_____

Address:_____

Email:_____

Reason for Visit:_____

Primary Care Physician:_____

If you are a new patient, let us know how you heard about us:

☐ Google ☐ Website ☐ Social Media ☐ Word of Mouth ☐ Other : _____

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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:

_____

_

Patient's Date of Birth:_____

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.

***You can cancel this authorization in writing at any time.**

☐ I do not wish to share any of my information

Signature:_____**Date:**____

_____

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

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If Patient is under 18, Relationship to minor:_____

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.

Patient Name (print):_____

Signature of Responsible Party (if not patient):_____

Patient Signature: _____Date:_____

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HIPPA PRIVACY POLICY

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 understands 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):_____

Signature of Responsible Party (if not patient):_____

Patient Signature:_____Date:_____

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