PATIENT INFORMATION

VISION SOURCE Family Eye Care Lebanon

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

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

Home Phone#: _____ Cell Phone#: _____ E-Mail: _____

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

Primary Care Physician: _____ Pharmacy: _____

Current Employer: _____ Phone#: _____

Emergency Contact Person *Outside Patient's Home*: _____Phone#: _____

FINANCIAL RESPONSIBILITY & Consent to Treat-by signing you agree you have read and agree to the following policies:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I also authorize Vision Source Family Eyecare or my insurance company to release any information required to process my claims. I understand that all benefits quoted to me are not a guarantee of payment from my insurance company, and that final determination can only be made when the claim is processed. I understand that I am financially responsible for any balances due I agree to a $25.00 insufficient funds fee, if my check is returned and agree payment will need to be in cash. I acknowledge I agree to Family Eyecare's Warranty/Return/Refund policy for materials and I also understand no refund will be given for physician services. I understand by signing this form below I am giving consent to be examined and treated which may include tests, procedures and non-covered services by insurance. I understand that I am financially responsible for any balances due for services provided.

X_____ Date: _____
Signature of Patient

ACKNOWLEGEMENT OF PRIVACY PRACTICES & HIPAA Communication Preferences:

- By signing I acknowledge a "Notice of Privacy Practices" that describes how my protected health information is used and disclosed, has been made available to me to read upon request.

X_____ Date: _____
Signature of Patient

- HIPAA Authorization to disclose protected health information. **I authorize Vision Source Family Eyecare to discuss and disclose my health care or billing information with the person I have listed below**. Please choose how we can communicate with them:

Name of Contact: _____ Relationship to you: _____
Please Print

Phone and/or email for contact: _____ Phone ☐ Email ☐ Both ☐

Please choose 1: Today I prefer:

( ) **OPTOS Test -No Dilation required with this test * $29.00 due today (Not covered by most insurance)**

- **Computer image of the retina that the physician will show you in the exam room.**
- *Allows the physician to compare images from year to year and to monitor changes in health.*

( ) **Dilation Only- Included in exam- No Cost**

- *Side effects are light sensitivity and blurriness.*

*Are You Interested in information about **contact lenses** today?* ☐ ***Yes*** ☐ ***No***

No-Show, Late, Confirmation and Cancellation Policy

Description

"No Show" shall mean any patient who fails to arrive for a scheduled appointment.

"Confirmation" shall mean any patient who fails to confirm by responding to our call, text or email after 3 pm the day before their scheduled appointment.

"Cancellation Cut Off" shall mean any patient who cancels an appointment after 3 pm the day before their scheduled appointment.

"Late Arrival" shall mean any patient who arrives at the clinic 10 minutes after the expected arrival time for the scheduled appointment.

Policy

It is the policy of the practice to monitor and manage appointment no-shows and late cancellations. Vision Source Family Eye Care's goal is to provide excellent care to each patient in a timely manner. It is required for patients to confirm an appointment by call, text or leaving a message no later than 3 pm on the business day before their appointment time. The same applies if cancellation is necessary. **Notification allows the practice to better utilize appointments for other patients in need of prompt optical care.**

Procedure

I. A patient is notified of the appointment "No-Show, Late, & Cancellation Policy" at the time of scheduling. This policy can and will be provided in writing to patients at their request.

II. Scheduled patients:

a. Appointment confirmation must be received no later than 3 pm on the business day prior to your scheduled appointment. Our confirmation system sends text messages, calls or emails based on your preference, a minimum of 3 times before appointment day arrives. If a response is not received, your appointed time may be offered to those on our waiting list.

b. Appointment must be cancelled no later than 3 pm on the business day prior to the scheduled appointment time.

c. In the event a patient arrives late as defined by "late arrival" to their appointment, and cannot be seen by the provider on the same day, they will be rescheduled for a future clinic visit, if available.

c. In the event a patient has incurred three (3) documented "no-shows" and/or "same-day cancellations," the patient may be subject to dismissal from Vision Source Family Eye Care.