VISION VERITAS
eyecare eyewear

Patient Information:

Date: _____

Patient's Full Legal Name: _____ DOB: _____ Sex: M F

SS#: _____ Race: _____ Ethnicity: _____ Marital Status: _____

Patient's Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Daytime Phone: _____

Email: _____ Approved Communication: (circle all applicable) Text Email Phone Mail

Employment/Student Status: (circle one) Full Time Part Time Retired Unemployed Student

Employer: _____ Occupation: _____

How did you hear about us? _____

Insurance Information:

Medical Insurance: _____ Phone #: _____

Member/Subscriber ID #: _____ Group/Acct #: _____

Vision Insurance: _____ Phone #: _____

Member ID #: _____ Group/Plan #: _____

**If you are not the guarantor/primary policy holder, please enter that individual's information below:*

Guarantor's Name: _____ Relationship to Patient: (circle one) Spouse Parent Other

DOB: _____ SS#: _____ Sex: M F Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Daytime Phone: _____

Please note that the above information is required in order for us to file your examination to your insurance. Please do not leave any section blank as it will delay filing your insurance and may result in a denial from your insurance company.

Required Signatures:

Financial Policies and Patient Responsibility:

Vision Veritas does its best to accurately obtain your coverage and charge you in accordance to your insurance benefits. While we will do everything we can to keep you informed of covered vs. non-covered services (as quoted by your insurance company), final determination of coverage and payment is not made until your insurance claim is reviewed by your insurance company. By signing below, you understand that payment collected today is based on a quote from your insurance company and is not a guarantee of benefits. In cases where professional goods and services are not covered (therefore, denied) by your insurance company, it will be the patient's responsibility to pay for these services in full. Claims not paid due to errant or undisclosed insurance information provided by the patient will be the responsibility of the patient as well. If we are not on your insurance plan, we require full payment for all services and products at the time they are rendered, but will provide you with an itemized receipt that you may submit to your insurance plan for potential reimbursement.

I have read and understand the financial policy of Vision Veritas and I do accept financial responsibility:

_____ _____

(Signature of Responsible Party) (Date)

Vision vs. Medical Insurance and Assignment of Insurance Benefits:

Vision insurance coverage is designed to cover routine eye services and to determine a glasses and/or contact lens prescription. When a medical condition or diagnosis is present, it may be necessary to file your examination to your medical insurance. Many times, we may not be aware of any medical diagnosis beforehand. These rules are often dictated by the insurance carriers themselves. Should this situation arise, we will do our best to inform you as to whether we will file your examination to your vision or medical insurance. In either case, the patient is responsible for any financial responsibility as dictated by their respective insurance company.

I authorize the payment of my medical/vision benefits to Vision Veritas. I authorize Vision Veritas to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

_____ _____

(Signature of Responsible Party) (Date)

Consent to Treat a Minor:

By law, any child under 18 years of age cannot be seen by a doctor without consent from a parent or legal guardian. If a child arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Name of individual who may act on Parent/Legal Guardians behalf: _____ _____

(Name) (Relation to Patient)

Signature of Parent/Legal Guardian: _____ Date: _____

No Show/Cancellation Policy:

Your appointment time is reserved specifically for you. A missed appointment leaves an empty slot that could have been used by another patient in need of medical/vision care. In fairness to other patients, we ask that ***you give us at least 24-hrs notice in advance of your appointment if you need to reschedule or cancel.*** *Failure to do so may result in* ***a $40 rescheduling fee*** *that is due at time of booking should you want to reschedule with us. If you show up to that rescheduled appointment, that $40 fee can be applied to any out-of-pocket charges you may incur. We reserve the right to modify this policy at any time at our discretion.*

_____ _____

(Signature of Responsible Party) (Date)

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MEDICAL HISTORY QUESTIONNAIRE

Personal Information **Date: ___/___/___**

Name: _____ DOB: _____ Gender: M / F

Last Eye Exam: ___/___/____ Name of Last Eye Doctor: _____ Pharmacy Tel/Fax:_____

Last Medical Exam: ___/___/____ Name/Contact Info of Primary Care Physician: _____

Ocular History

Please **√ check** all that apply. **Please put date of diagnosis and/or family member if applicable.**

	SELF Date Diagnosed?	FAMILY Who?		SELF Date Diagnosed?	FAMILY Who?
Glaucoma			Dry Eye		
Cataracts			Eye Allergies		
Macular Degeneration			Eye Surgery		
Strabismus (Lazy/Crossed Eye)			Eye Injury/Trauma		
Retinal Detachment/Tear			Blindness		
Flashes/Floaters			Other:		

Medical History

Please **√ check** all that apply. **Please put date of diagnosis and/or family member if applicable.**

	SELF Date Diagnosed?	FAMILY Who?		SELF Date Diagnosed	FAMILY Who?
Diabetes			Cancer (what type?)		
High Blood Pressure			Thyroid Disease		
High Cholesterol			Arthritis		
Heart Disease			Auto-immune disease		
Asthma/Emphysema/ Sleep Apnea			Seasonal Allergies		
Major Injuries/Surgeries			Other:		

Please turn over

VISION SOURCE

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Vision Veritas make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

PLEASE CHOOSE ONE OF THE FOLLOWING:

- ☐ I have read or had explained to me Vision Veritas Notice of Privacy Practice and agree to continue my care with Vision Veritas under said terms.
- ☐ I have read or had explained to me Vision Veritas Notice of Privacy Practice and do not wish to continue my care with Vision Veritas under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

_____

_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Date

If you are signing this as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have the legal authority to make medical decisions for the minor. Please indicate any other parent, step-parent, guardian or other individual(s) authorized to make medical decisions for the minor.

_____ _____

_____ _____

Representative Signature Relationship to Patient

Please list the names and relationships of all people to whom we may disclose your private health information:

Name: _____ Relationship: _____

_____ _____

_____ _____

Social History			
Do you use Tobacco Products?	Yes	No	Type/How Often?
Do you drink Alcohol?	Yes	No	Type/How Often?
Do you use illegal drugs?	Yes	No	Type/How Often?

Are you currently pregnant or nursing? NO YES

Do you have allergies to any medications? NO YES
If YES, please list: _____

Please list any medications you are currently taking (including over-the-counter and vitamins): _____
_____
_____

Review of Systems If you are currently having any problems in the following areas, please circle and explain.	
Cardiovascular: chest pain, shortness of breath, high blood pressure, high cholesterol, other	O none
Constitutional: fever, recent large weight loss or gain, other	O none
Ears, Nose, Throat: ringing ears, sinus congestion, hay fever/allergies, dry mouth, other	O none
Endocrine: Thyroid disease, Diabetes, other	O none
Gastrointestinal: vomiting, constipation, diarrhea, other	O none
Genitourinary: painful/difficult urination, kidney stones, other	O none
Hematologic/Lymphatic: anemia, bleeding problems, tender lymph nodes, other	O none
Immunologic: Sjogrens, Lupus, Arthritis, Multiple Sclerosis, other	O none
Skin: rash, skin lesions, shingles, other	O none
Musculoskeletal: back pain, joint pain, other	O none
Neurological: seizures, headache, migraine, numbness/tingling, other	O none
Psychiatric: anxiety, depression, insomnia, other	O none
Respiratory: COPD/emphysema, asthma, difficulty breathing, cough, other	O none
Infectious: HIV/AIDS, Hepatitis, Syphilis, Herpes, Gonorrhea, other	O none

Vision Veritas Contact Lens Evaluation Agreement

If you are interested in contact lenses, please read and sign the following:

What is a contact lens evaluation?

A contact lens evaluation is an additional, separate portion of a comprehensive eye examination. As contact lenses are most often an elective addition to a glasses prescription, most insurance companies do not cover contact lens evaluations in full. Any contact lens evaluation fees that are not covered by insurance will be the responsibility of the patient. At Vision Veritas, our contact lens evaluation fees begin at $115 and are dependent on the type of contact lens being fit. Since contact lens prescriptions expire after 1 year, contact lens evaluations are required on an annual basis. Contact lens evaluations do not include the actual supply of contact lenses.

What is included in a contact lens evaluation?

- Determination of candidacy for contact lens wear
- Determination of contact lens prescriptions based on glasses prescriptions
- Evaluation of tear film and cornea
- Evaluation of contacts on the eye
- Topographical analysis of cornea if necessary
- Insertion/removal training for first time wearers
- Contact lens trials until determination of final prescription
- Travel size contact lens solution and case
- Any contact lens related follow-ups for a period of 6 months. Any contact lens follow-up after 6 months will incur a $70 fee.

I have read and agree to the terms of the Contact Lens Evaluation Agreement.

_____	_____	_____
Printed Name	Signature	Date