VISION SOURCE®
Meyer Park

PATIENT CHECK-IN

Date _____ Appt Time _____

New Patient _____ Existing Patient _____

Last Name | First Name | MI | Date-of-Birth | Last 4 of SSN

Address | City, State | Zip Code | Male OR Female

Cell # | Alt # | Email

Vision Insurance | Primary/Subscriber Name | Member ID or SSN

ACTIVITIES (Check all that apply)

- ☐ Swimming
- ☐ Hunting
- ☐ Fishing
- ☐ Gardening
- ☐ Night driving
- ☐ Sewing/knitting
- ☐ Comp/phone/tablet _____ hrs/day
- ☐ Other _____

INTERESTED IN (Check all that apply)

- ☐ Laser vision correction
- ☐ Progressive lenses
- ☐ Thinner, lighter lenses
- ☐ Sports/safety goggles
- ☐ Computer glasses
- ☐ Sunglasses
- ☐ Transition lenses
- ☐ Other _____
- ☐ Contacts
- ☐ Contacts I can sleep in
- ☐ Colored contacts
- ☐ Multi-focal contacts

PERSONAL HISTORY (Check all that apply) ☐ **SAME AS LAST YEAR**

- ☐ Blurry vision
- ☐ Floater/Spots
- ☐ Crossed eyes
- ☐ Eye surgery
- ☐ Eye infections
- ☐ Dry eyes
- ☐ Tearing
- ☐ Cataracts
- ☐ Burning eyes
- ☐ Double vision
- ☐ Eye injury
- ☐ Lazy eyes
- ☐ Itchy eyes
- ☐ Blindness
- ☐ Glaucoma
- ☐ Arthritis
- ☐ Headaches
- ☐ Heart disease
- ☐ Light sensitivity
- ☐ Grittiness in eyes
- ☐ Thyroid
- ☐ Asthma
- ☐ Cancer
- ☐ Allergies
- ☐ Diabetes
- ☐ Cholesterol
- ☐ Iritis/Uveitis
- ☐ Hypertension
- ☐ Smoking
- ☐ Other _____

FAMILY HISTORY (Check all that apply) ☐ **SAME AS LAST YEAR**

- ☐ Cancer
- ☐ Thyroid
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Blindness
- ☐ Cholesterol
- ☐ Hypertension
- ☐ Heart disease
- ☐ Iritis/Uveitis
- ☐ Macular degeneration
- ☐ Other _____

LIST CURRENT MEDICATIONS: _____

OFFICE USE ONLY

☐ Comp Exam	159
☐ Refraction	45
☐ Optos	30
☐ CL Fit Sphere	60
☐ CL Fit Toric	80
☐ CL Fit MF	90
☐ CL Fit RGP	130
☐ CL Fit Specialty	300
☐ Office Visit L1	
☐ Office Visit L2	
☐ Office Visit L3	

- ☐ Order contacts
- ☐ Call to order contacts
- ☐ Follow-up required
- ☐ Order trials

- ☐ Dr. Lai
- ☐ Dr. Le
- ☐ Other

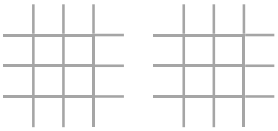
_____

PRELIMINARY TESTING

OD _____

OS _____

IOP _____



PREVIOUS RX

OD _____

OS _____

PREVIOUS CONTACT RX

OD _____

OS _____

FINAL RX

OD _____

OS _____

FINAL CONTACT RX

OD _____

OS _____

VISION SOURCE™
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Service Fees	All professional services (exam, contact lens fitting, and/or follow-up fees) are non-refundable.	_____
Cancellation	An optical order can be cancelled for a full refund only if the job has not been processed. Once processed, there will be a **50%** cancellation fee for the cost of the lens. A restocking fee of **$30** will apply for the frames.	_____
Outside RX	A valid prescription from another office may be filled at our establishment. If a doctor's change in prescription is needed, one lens remake can be processed within 60 days of the original order at no additional cost. The prescribing doctor must provide a new prescription in writing before the remake. For any additional changes, a fee will be applied.	_____
Non-Adaptation	Due to the complex nature of glasses, patients are encouraged to give their eyes time to adapt to a new prescription. Patients are entitled to ***one*** remake if adaptation does not occur; order must be processed within 60 days of the original purchase date. There is no refund for the difference in cost if the new lenses are of lesser value.	_____
Contacts	Contacts may not be returned if the boxes have been opened or if the packaging has damage of any kind. A refund may be given if the boxes are unopened. A 10% restocking fee will be deducted from the refund.	_____

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our offices.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or benefits and payment our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our website.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and perform health care operations. By signing, you signify that you have no other health or vision insurance (or that you have provided us all insurance information) and agree that, since there is no guarantee of payment by an insurance company, you will be responsible for payment for services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

We have the right to ask us to restrict the use or disclosures made for purposes of treatment, payment of health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, these restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEATLH INFORMATION FOR PURPOSES OR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

_____ _____
Date Signature of Patient

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

_____ _____
Relationship to Patient Print Name

_____
Source of Authority