VISION SOURCE® of Hot Springs

200 S. Chicago Street
Hot Springs, SD 57747
PH 605-745-3175
FAX 605-549-8170
info@visionsourcehs.com

Name: _____ Preferred Name: _____ Date of Birth: _____

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____ Patient SS#: _____

(If under 18) Parent/Guardian: _____ Parent SS#: _____

INSURANCE

Please provide our office with copies of all insurance cards and a photo ID.

Primary Policy Holder: Self (circle) **OR** If not self, please complete below:

Name: _____ Date of Birth: _____ SS# _____

NOTICE OF PRIVACY POLICY

By signing below, I verify that I am aware that a copy of the Notice of Privacy Policy is available in the reception area.

SIGNATURE OF INSURANCE ASSIGNMENT

Verify your insurance benefits and pre-authorization requirements. Be mindful of your deductible, co-pay and out of pocket co-insurance amounts. As a courtesy, we will submit a claim to your Health Care Plan, if applicable. Co-pays are due on the date of service. You are responsible for any remaining balances. Balances over 90 days will be sent to collections.

By signing below, I authorize payment of medical/vision benefits to Vision Source for services or ophthalmic products. I authorize release of any medical or other information necessary to process claims.

_____ _____

Patient/Guardian Signature **Date**

PLEASE CONTINUE TO BACK SIDE

Other Providers

Primary Doctor_____

Specialty Doctor_____

Pharmacy_____

Social History (circle Yes or No)

Drink: Yes / No

Amount (If yes): _____

Tobacco Use: Yes / No

Tobacco Type (Circle all that apply if 'Yes'):

Cigarettes / Cigars / Pipes / Smokeless Tobacco

Amount: _____

(Circle one) Every Day Use / Some Day Use

Former Smoker: Yes / No

Race

◯ American Indian ◯ Asian ◯ Black/African American ◯ Other Race ◯ White

Ethnicity

◯ Hispanic or Latino ◯ Not Hispanic or Latino

Please review list below and check any conditions you currently have or are currently being treated for (check all that apply):

Constitutional

- ☐ Developmental Disabilities
- ☐ Cancer
- ☐ Fatigue Syndrome
- ☐ Other: _____

Ear, Nose, Throat

- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis
- ☐ Other: _____

Neurological

- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Tumor
- ☐ Stroke
- ☐ Migraine
- ☐ Other: _____

Psychiatric

- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety
- ☐ Bipolar
- ☐ Other: _____

Cardiovascular

- ☐ Hypertension
- ☐ Stroke
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Other: _____

Respiratory

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea
- ☐ Other: _____

Gastrointestinal

- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Other: _____

Genitourinary

- ☐ Kidney Disease
- ☐ Prostate
- ☐ STD
- ☐ Pregnant
- ☐ Nursing
- ☐ Other: _____

Muscular Skeletal

- ☐ Osteoarthritis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Gout
- ☐ Other: _____

Integumentary

- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Cold Sores
- ☐ Shingles
- ☐ Other: _____

Endocrine

- ☐ Type 2 Diabetes
- ☐ Type 1 Diabetes
- ☐ Thyroid
- ☐ Hormonal Dysfunction
- ☐ Other: _____

Hematologic/ Lymphatic

- ☐ Anemia
- ☐ Large volume blood loss
- ☐ Ulcer
- ☐ Cholesterol
- ☐ Other: _____

Allergy/ Immune

- ☐ Drug allergies
- ☐ Environmental Allergies
- ☐ Rheumatoid Arthritis
- ☐ Sjorgen's syndrome
- ☐ Other: _____

Eyes		
☐ Vision Loss ☐ Blurry Vision ☐ Distorted Vision ☐ Double Vision ☐ Dryness ☐ Tired Eyes	☐ Gritty Feeling ☐ Mucous Discharge ☐ Redness ☐ Itching ☐ Burning ☐ Excess Watering	☐ Light Sensitivity ☐ Eye Pain/Soreness ☐ Styes ☐ Flashes ☐ Floating Spots ☐ Other: _____
Previous Eyecare Professional _____ **Date of last Eye Exam** _____	**Do you wear glasses?** ☐ Yes ☐ No If Yes, how old are they? _____	**Do you wear contact lenses?** ☐ Yes ☐ No If Yes, what brand? _____ How often do you replace them? _____

Medications:

Ocular History (Check All That Apply):	**Medication / Environmental Allergies:**
☐ Cataracts ☐ Diabetic Retinopathy ☐ Glaucoma ☐ Macular Degeneration ☐ Retinal Detachment ☐ Other: _____	
Ocular Surgeries: ☐ Cataract Surgery ☐ Lasik / PRK ☐ Other: _____	**Latex Sensitivity (Circle one):** Yes / No

Family Ocular History: Note relation to yourself

Please list (F) father, (M) mother, (S) sister, (B) brother, (So) son, (D) daughter

☐ Cataracts _____

☐ Macular Degeneration _____

☐ Glaucoma _____

ROUTINE VISION EXAMS VS. MEDICAL EYE EXAMS

There are important differences between these two types of examinations and these differences determine how the visit can be billed.

Also, a provider can be participating providers with your medical plan but NOT the vision plan. You are responsible for knowing your coverage.

Insurance defines **routine** exams as the purpose of checking vision, screening for disease, and updating eyeglass prescriptions. Only **routine** exams can be submitted to vision discount plans such as EyeMed, Fep Blue, Davis, MetLife or VSP. By law, Medicare (and most commercial health insurances) do NOT allow us to submit routine vision exams, refractions, contact lenses or contact lens fitting fees.

If the reason for your visit is a routine vision exam for glasses or contacts and there are no medical complaints, this is considered a routine only exam. If the doctor finds an eye health **medical** condition (ie. Glaucoma, Dry Eye Syndrome) during this visit it is still considered a routine exam. However, any necessary future testing/visits related to that eye health medical condition can be billed to medical insurance due to the requirement to use medical coding.

If the reason for your visit is to follow up on an existing medical condition (ie. Diabetic Retinopathy, Glaucoma, Macular Degeneration), an eye complaint or emergency, we then are required to use medical coding and will therefore submit to **medical** insurance.

Refraction-A refraction is the test in which different lens combinations are presented to you "which is clearer, choice one or choice two". Your response is what helps determine your new eyeglass prescription.

Medicare and most commercial health insurances do not consider a refraction to be a "medically necessary" service and therefore do not accept submissions for this part of the exam.

Remember: It is the patient's responsibility to know their insurance, policy coverage, and if our doctor is participating provider in their plan. Insurance "coverage" does not necessarily mean insurance "payment". Many health plans have required co pays and deductibles that must be met before they pay toward your bill.