CHARLESTON VISION SOURCE

Medical History Questionnaire

Today's Date: _____

Last Name: _____ First Name: _____ MI: ____ Salutation: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Phone: Home _____Cell _____ Work _____ Male / Female

Social Security # _____ Email: _____ DOB: _____

Race: _____ Preferred Communication: Text ____ Email____ Phone ____

Ethnicity (Circle one) Hispanic or Latino Not Hispanic or Latino Unknown

Height: ft _____ in_____ Weight: _____ lbs Preferred Language: _____ Physician: _____

Guardian: _____ Guardian Birthdate: _____

Emergency Contact: _____ Phone: _____Referred By: _____

Employer Info: _____ Occupation: _____

Vision Insurance: _____ID:_____ Patient Relationship to Policy Holder: _____

Policy Holder Name: _____ Birthdate: _____ Social Security # _____

Medical Insurance: _____ID:_____ Patient Relationship to Policy Holder: _____

Policy Holder Name: _____ Birthdate: _____ Social Security # _____

Past Surgeries

Date	Surgery Type	Location	Surgeon

TURN OVER

Current Problems and Year Diagnosed: **Current Medications including over the counter:**

__ High Cholesterol _____ _____

__ High Blood Pressure _____ _____

__ Diabetes _____ _____

__ Thyroid Disease _____ _____

__ Rheumatoid Arthritis _____ _____

Allergy History: _____

Have you been exposed / infected with Gonorrhea, Hepatitis, HIV or Syphilis? Yes or No

EYE DISEASES (Family or Self)

_____ Lazy Eye

_____ Macular Degeneration

_____ Blindness

_____ Cataracts

_____ Color Blindness

_____ Diabetic Retinopathy

_____ Dry Eye Syndrome

_____ Eye Injuries

_____ Glaucoma or Suspect

_____ Retinal Detachment

CURRENT EYE SYMPTOMS

__ Glare Sensitivity
__ Headaches
__ Light Sensitivity
__ Tired Eyes
__ Burning
__ Dryness
__ Watering
__ Eye Lid Swelling
__ Eye Pain or Soreness
__ Foreign Body Sensation
__ Infection on Eyelid
__ Itching
__ Redness
__ Sandy or Gritty Feeling
__ Blurred Vision Distance
__ Blurred Vision Near
__ Distorted Vision
__ Double Vision
__ Flashes of Lights
__ Floaters or spots
__ Fluctuating Vision
__ Loss of central vision
__ Loss of side vision
__ Loss of vision
__ Mucous
__ Ptosis (Drooping Lids)

Other additional notes: _____

If diagnosed with Diabetes, who is your Endocrinologist? _____

A1C % _____ **When?** _____ **Blood Sugar** _____ **When?** _____

Do you currently… **Are you interested in …** **Would you change anything about your current**

___ Wear Glasses **___ Glasses** **eyewear or contacts? _____**

___ Wear Contacts **___ Contacts** **_____**

___ Use Nicotine **___ LASIK**

I give permission for Charleston Vision Source to give me medical treatment. I allow Charleston Vision Source to file for insurance benefits to pay for the care I receive. I understand that: Charleston Vision Source will have to send my medical record information to my insurance company. I must pay my share of the costs. I must pay for the cost of these services if my insurance does not pay or I do not have insurance. I understand: I have the right to refuse any procedure or treatment. I have the right to discuss all medical treatments with my clinician.

FINANCIAL AND BILLING POLICIES: [EFFECTIVE 03/01/2022] **Patient Co-Payments:** Patients at Charleston Vision Source will be asked to present any insurance cards at each visit. All co-payments and any past due balances are due at the time of check-out unless previous arrangements have been made with our billing manager. We accept cash, check, credit card or Care Credit at time of payment. **No post-dated checks will be accepted.**
Refractive Services: I understand that the $45.00 refraction fee is NOT covered by medical insurance even though it is considered part of the comprehensive eye exam at Charleston Vision Source. I understand that I am responsible for payment of the fee unless I request not to have a refraction performed prior to the examination. The refraction is the part of the eye examination performed to prescribe glasses and/or contact lenses.
Insurance Claims: Your personal insurance is a contract between you and your insurance company. We will bill your primary insurance company after the completion of your visit. In order to bill your insurance company, we require that you disclose all vision and health insurance information including primary and secondary insurance. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Your insurance company will make the final determination of your eligibility and benefits. If we are out of network with your insurance provider, you are responsible for the charges incurred at your appointment. We may offer to bill out of network insurances for reimbursement as a courtesy. If we are forced to submit your account to an outside collection agency, there will be a $50.00 charge added to the account and all future appointments scheduled for the account will be canceled and not rescheduled until the balance is paid in full. **Referrals and Pre-Authorizations:** There are health insurance companies that require the patient to obtain a referral or prior authorization form from your Primary Care Provider before visiting a specialist. If your insurance company requires a referral or pre-authorization, the patient is responsible for obtaining it. Failure to obtain the referral along with the pre-authorization may result in a lower or no payment from the insurance company, and the outstanding balance will be the patient's responsibility. This may require the patient's appointment to be rescheduled if not obtained before seeing the doctor. **Third Party Billing and Worker's Compensation:** Charleston Vision Source does not participate in any third-party billing or Worker's Compensation claims.

OPTICAL POLICIES: If a patient orders glasses, full payment is due at the time of the order. When glasses are dispensed to the patient, any remaining balance on the patient/family account is also due in full. **No Refunds or Canceled Orders:** Due to the customized design and fit of your lenses/frames, we are not able to offer refunds or cancel orders that the lab has already started. **100% Satisfaction Guarantee:** If you are not satisfied with your new, customized lenses, we offer a one-time glasses prescription change at no extra charge within 30 days. After 30 days, you will be subject to a $45.00 refraction charge. If you are not satisfied with your new frame purchase, we offer a one-time frame exchange with a $50.00 restocking fee. If the frame selected for exchange exceeds the amount of the original frame purchased, you will have to pay the difference in cost. We do not offer refunds if the frame selected is less than the original frame purchased due to the cost of customized lens remakes and the return process of the frame to the manufacturer. **Insurance Glasses May Have Restrictions:** Some insurance companies (including VSP and Eyemed) and their labs have more restrictive warranties that we are contracted to follow. Some plans may not allow you to change your frame or lens design once your glasses have been ordered. **30 Day Non-Adapt Policy:** If you are not able to adapt to your progressive/no-line bifocal lenses, we will remake them into one pair of single vision lenses or lined bifocal lenses at no cost to you. Original fees cannot be refunded.
Frame Warranties: Our frame warranty covers manufacturer defects for one year from the date of dispense. Accidental damages/breakages are not covered under warranty. **Scratch Warranty:** All prescription lenses ordered with a no glare property have a scratch warranty available for the life of the patient's prescription. **Using Your Own Frame:** Due to the unknown quality and/or condition of a patient's own we cannot accept responsibility for any damage or breakage that may occur during lens insertion or frame adjustments. **Outside Prescriptions:** We are happy to fill an outside prescription, but if you have an issue with your vision that is related to the prescription itself you must go back to the prescribing doctor to be reevaluated. The new prescription must be provided within 30 days of the dispense for a one-time remake. You may also opt to see one of the doctors in our office for a $45.00 refraction fee.

CONTACT LENS POLICIES: **Disposable Contact Lens Purchases:** Although we keep some disposable contact lenses in our office, most of them must be ordered from our distributor. Most annual supplies of disposable contact lenses may be shipped to you at no cost, but others (or smaller quantities) can be shipped to you for $15.00. Any contact lens orders not picked up within 30 business days that have been shipped to our office will be returned to the distributor and the patient's account will be credited for the amount they paid, less the $15.00 shipping charge. Contact lenses cannot be returned unless the patient has purchased an annual supply and has had a prescription change within the life of their contact lens prescription. Any open or damaged boxes cannot be returned.
Specialty Contact Lens Products: Patients who need to be fit into specialty contact lenses are required to pay for their fitting and their contacts in full prior to the dispensing and evaluation of the products. Patients will be advised of pricing before specialty contact lenses are ordered/fit.

APPOINTMENT POLICIES: **Missed Appointments:** As specialists, we require that patients call, text, or email our office at least 24 hours before their scheduled appointments to make any changes or cancellations. Any appointment that is canceled or rescheduled will be charged a $30.00 no show fee. Once applied to the account you must pay that balance before any appointments are scheduled. If your account exceeds 3 no show fees, you will be restricted to same day appointments with our office. **Minors:** Any patient under the age of 18 must be accompanied by a parent or guardian for all visits. This accompanying adult is responsible for any payments due at the time of service. Any patient 18 or older receiving treatment at our office is fully responsible for payment of all services. We will not bill any other personal party. **Copies of Medical Records and Special Reports:** There is a $10.00 charge for medical records and special reports of any kind. Medical records are also subject to a charge of $0.75 per page, plus postage if mailing is needed.

I understand the policies of Charleston Vision Source and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice. **Your Information. Your Rights. Our Responsibilities.** This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. **Your Rights when it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you. **Get an electronic or paper copy of your medical record:** You can ask to see

or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. **Ask us to correct your medical record:** You can ask us to correct health information about you that is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Buying Glasses Online

The quality of vision you achieve in your eyewear is directly related to the quality of the materials used to fill your prescription. We are not responsible for any loss of clarity or discomfort experienced from eyewear purchased online or from commercial eyewear retailers. If a follow up examination to check the prescription is required, there will be a $45.00 charge unless changes are required in the prescription. This charge is waived if you purchase your eyewear here.

Recent studies show nearly half of online glasses orders were either filled with an incorrect prescription or had safety issues. Of the children's styles tested, nearly one third failed impact testing. We encourage you to return with your glasses and allow us to check the accuracy of the eyewear.

If you need a P.D. (pupillary distance) measurement, the charge will be $10.00.

Billing Disclaimer and Office Policy Acknowledgement

We are happy to bill your insurance company on your behalf when possible, but please understand that if your insurance company does not pay in full, YOU are responsible for the balance.

All copays or costs for services are due at the time of service.

I acknowledge that I have read and understand all polices and Notice of Privacy Practices noted above.

Patient name: _____ Date: ____/____/____

Parent / Guardian: _____

Signature: _____