VisionArts
Eyecare Center
Eye Health Wellness Rejuvenation

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visionartseyecare.com

Dr. James W. Vann, Optometrist

As a new patient to our practice, we would like to offer a warm welcome and thank you for choosing us as your eye health and vision care provider. In order for Dr. Vann and our staff to provide you with the best care possible, the following information must be provided. Please complete the check list and bring the information with you to your appointment.

- □ **Completed *Welcome to our Office* Form**: This diagnostic information includes personal and family information needed to establish your file, as well as your current eye health and vision status. Your responses will guide our doctors and staff, and remind us to address any significant issues during your visit.
- □ **Completed Medical and Eye Health History:** Many general health conditions may be associated with visual symptoms and/or eye health problems, so this important information will allow us to care for you as a whole person rather than just a pair of eyes. This form includes a complete list of prescription and non-prescription medication, which may be brought in as a separate list for us to photocopy if you prefer.
- □ **Completed Patient Lifestyle Questionnaire:** We offer endless options which allow us to customize your lenses to fit your lifestyle and your specific needs. With this important information, Dr. Vann and his opticians will have the ability to provide you with the best vision and clarity possible from your new glasses.
- □ **Insurance cards or claim forms:** For any optical or medical insurance coverage you have.
- □ **Eyeglasses:** Please bring EVERY pair of eyeglasses you currently use, including prescription or non-prescription reading glasses, sunglasses, etc.
- □ **Contact Lenses:** It is best to wear your current contacts to your appointment if possible. Next best is to bring them along in your case. It is also very helpful if you bring along your cartons or lens packets that indicate the lens series, power, manufacture, etc.

It is important for Dr. Vann to check the health of your eyes in one of two ways, so please be prepared to make the following decision:

Dilation vs. Optomap:

An Optomap retinal screening takes a few seconds and provides an in-depth view of the retinal layers where disease starts. A permanent photographic record is created for your medical file, which gives Dr. Vann comparisons for tracking and diagnosing potential disease and allows for him to review your retinal image with you during your exam. Though most insurance companies do not cover advanced screening technologies such as Optomap, Dr. Vann believes it is in your best medical interest to have an Optomap retinal scan at each exam. **The optomap fee is $39.**

Dilation is included in the cost of the exam. It requires dilating drops that may cause momentary stinging or burning to your eyes. These drops temporarily paralyze ocular muscles, which result in blurred vision and light sensitivity for 6-12 hours. Dilation only allows Dr. Vann to see a pin point size portion of your eye at a time and he must piece the images together in his mind and then draw it out on paper in order to keep a permanent record of your current retinal health.

Finally, if we are filing your exam through your insurance company, please be aware the refraction is often a non-covered service. This necessary test is used to determine whether you have a refractive error (a need for glasses or contact lenses) and may cost you up to $22.

We make every effort to verify your insurance coverage prior to your appointment; however, this is only a *statement of benefits* and not a *guarantee of payment*. Final determination of payment will be made by your insurance company after they receive your claim. Should there be a discrepancy between the payment we collected from you and the payment we receive from your insurance company, we will either refund you or charge you the difference.

Thank you for completing the above task list. This will ensure that you receive the most thorough and professional care possible. We look forward to your visit!

Welcome to Our Office

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Patient Information

Today's Date _____

Last Name _____First Name _____MI _____

Street _____ City _____ State_____ Zip Code_____

Home Phone _____Work Phone _____Cell Phone _____

Email Address _____ □ Decline

Marital Status □ Never Married □ Married □ Domestic Partnership □ Divorced □ Widowed

Patient's SSN _____ Date of Birth _____ Age ____

Employer or School _____ Occupation or Grade _____ □ Disabled □ Retired

Spouse or Parent's Name _____

Spouse or Parent's Employer _____

Insurance Information

Do have medical insurance? ☐ Yes ☐ No

Do have vision insurance? ☐ Yes ☐ No

Do you participate in a health savings or flex spending account? ☐ Yes ☐ No

Current Medications

If you did not bring a list of current medications, please list them below. Include all prescription and over the counter medications taken on a regular basis, as well as, eye drops, vitamins, & birth control pills.

_____

_____

_____

Preferred Method(s) of Contact

We want to contact you via the method(s) most convenient for you. Please select your preferences below:

Appointment Confirmations and Reminders

__Text __Email __Home Ph. __Cell Ph. __Work Ph.

Newsletters, Events, and Promotions

__Text __Email

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Notice of Privacy Practices

The law requires that VisionArts Eyecare Center make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that I have reviewed or have been given the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where, and why my confidential health information may be used or shared.

➡ **Initial here:____**

Release of Information Form

Due to federal privacy regulations, we cannot leave messages with protected health information on home answering machines or speak with family members without written permission from the patient. Please complete the form below to ensure your privacy needs are met to your specifications.

I give VisionArts Eyecare Center permission to leave detailed messages:

☐ On my home answering machine/ voicemail (____)_____

☐ On my work answering machine/ voicemail (____)_____

☐ On my cell phone voice mail (____)_____

☐ **I do not want any messages left on my answering machine/ voice mail.**

I give VisionArts Eyecare Center permission to speak with the person(s) listed below:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

☐ **I do not want any medical information released to anyone other than myself.**

➡ **Initial here:____**

Patient Statement of Financial Responsibility

We will verify your coverage and bill your insurance on your behalf; however, you are ultimately responsible for payment of your bill. **Any deductible or copayment, as determined by your insurance plan, is your responsibility. Those payments are due today at the time of your service.** You are also responsible for any amount not covered by your insurance. If your insurance denies any part of your claim, you will receive a bill for the remaining balance, and you will be responsible to pay the balance in full.

Payment for your portion of your glasses and/or contact lenses is required BEFORE they will be ordered.

We accept the following forms of payment:
Cash, Check, Visa, MasterCard, Discover Card, American Express, Care Credit

➡ **Initial here:____**

Patient/ Guardian Signature: _____ Date:_____