

Vision Source
1685 South Voss Road
Houston, TX 77057
Phone: (713) 954-2020
Fax: (713) 954-2046

**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 office.

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 and services provided here, but also 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 obtaining payment; our submission of claims to third-party payers or insurers, for claims review, determination of 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 Web site.

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 to 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 received in our office should the insurance not pay. You can revoke this consent in writing at any time unless we have already treated you; sought payment for our 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.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practices we are not obligated to agree to these suggested restrictions. However, if we do agree, the 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 HEALTH INFORMATION FOR PURPOSES OF TREATMENT,
PAYMENT, AND HEALTH CARE OPERATIONS.**

Dated

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

Dr. Rachel J. Rippey

Welcome to our office! We are glad that you have chosen us to provide your eye-care needs. Please complete this form and return it to the receptionist.

PATIENT RECORD

(Please Print)

DATE: _____

NAME		GENDER M <input type="checkbox"/> F <input type="checkbox"/>		HOME PHONE		WORK PHONE	
ADDRESS				BIRTHDATE		OCCUPATION	
CITY				STATE		ZIP	EMAIL ADDRESS
DATE OF LAST EXAM		LOCATION OF LAST EXAM			HOW DID YOU HEAR ABOUT OUR OFFICE?		
NAME OF EMPLOYER			LIST THE INSURANCE CARRIER THAT PROVIDES YOUR VISION BENEFITS				
			SOCIAL SECURITY NUMBER OF INSUREE - - - - -				

We will file insurance for any plan under which we are providers. If you have a question about which plans for which we are providers, please ask our receptionist. Payment is due at time of treatment.

WHAT TYPE OF EXAM ARE YOU HERE FOR?			REASON FOR TODAY'S EXAM		
<input type="checkbox"/> CONTACT LENS <input type="checkbox"/> SPECTACLE <input type="checkbox"/> BOTH					

CONTACT LENS PATIENTS

- Do you have any previous contact lens experience? No Yes
- Do you currently wear contact lenses? No Yes
- Are you interested in lenses, which enhance or change your eye color? No Yes
- Do you want to nap/sleep in your lenses? No Yes
- Do your eyes become dry, itchy or irritated while wearing contacts? No Yes
- Do your contacts become less comfortable as the day progresses? No Yes
- Are you interested in learning about the latest advances in contact lenses? No Yes

Type of lenses worn:
 Soft
 Extended Wear
 Gas Permeable
 Hard
 Bifocal
 Toric (astigmatism)
 Disposable
 Other

Age of present contact lenses: _____ Brand: _____ Solutions: _____

- Do you or any family member have Diabetes? Who? _____ No Yes
- Do you have any medical problems? No Yes
Describe _____
- Do you take any medication? No Yes
List: _____
- Are you pregnant? No Yes
- Do you have any allergies? List: _____ No Yes
- Do you have frequent headaches? No Yes
- Do you ever see double? No Yes
- Do you or any family member have Glaucoma? Who? _____ No Yes
- Do you or any family member have Cataracts? Who? _____ No Yes
- Does any family member have an eye disease? No Yes
Describe _____
- Have you ever had any eye disease, injury or surgery? No Yes
Describe _____