Welcome To Shawnee Vision Source

Travis Kliewer, O.D. **Kyle Karnish, O.D.**
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Please Fill In All Information

Legal Name:_____ **Sex:** (circle one) M F
(First) (MI) (Last) **DOB**:____/_____/_____ **Age**:_____
Preferred Name:_____ **Social Security Number**:_____-_____-_____
Address: _____ **Marital Status**: (**circle one**) Married Single Divorced Widow
City, State, Zip:_____ **Employment Status**: (**circle one**) Part-Time / Full-Time Student
Home Phone:_____ Part –Time / Full –Time Employed Unemployed Retired
Cell Phone:_____ **Text Ok**: Yes or No **Employer**:_____
Work Phone:_____ EXT._____ **Occupation**: _____
Email Address:_____
Primary Care Physician (Name/Location/Telephone)_____
How did you hear about us? Insurance_____ Saw Sign/Building____ Yellow Pages _____ Internet Search _____ Billboard_____
Friends/Family_____ **Name of Person** (if you were referred):_____

PLEASE CIRCLE ALL THAT APPLY:

Race: (**circle one**) America Indian , Asian , African American , Hispanic , Native Hawaiian/Pacific Islander , Caucasian

Ethnicity: (**circle one**) Hispanic/Latino , Not Hispanic/Latino , Native Hawaiian/Pacific Islander

Communication Preference: (**circle one**) Home Phone Cell Phone Daytime Phone Email Text

Where was your last exam?_____ **When was your last exam**? _____

Are you interested in? : Glasses (**circle one**) Yes or No Contacts (**circle one**) Yes or No Lasik Vision Correction (**circle one**) Yes or No

In order to file any insurance claims, we must copy ALL insurance cards at the time of visit.

The following questions must be answered completely:

Attach all Insurance Cards (Medical and Vision) and Drivers License or Government Issued ID

Insurance Information- (MUST BE FILLED OUT COMPLETELY WITH PRIMARY CARDHOLDERS INFORMATION)

Vision Insurance

Primary Cardholder Name: _____ Insurance Name:_____
Primary Cardholder DOB:_____/_____/_____ Insurance ID #:_____
Primary Cardholder SSN:_____-_____-_____ Group #_____
Primary Cardholder Address: (if different from above)_____
Primary Cardholder Phone: (if different from above) Home: _____ Cell: _____
Primary Cardholder Employer: (if different from above)_____

Medical Insurance

Primary Cardholder Name: _____ Insurance Name:_____
Primary Cardholder DOB:_____/_____/_____ Insurance ID #:_____
Primary Cardholder SSN:_____-_____-_____ Group #_____
Primary Cardholder Address: (if different from above)_____
Primary Cardholder Phone: (if different from above) Home: _____ Cell: _____
Primary Cardholder Employer: (if different from above)_____

IF YOU HAVE A SECONDARY MEDICAL OR VISION INSURANCE PLEASE NOTIFY THE RECEPTIONIST !

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY

I acknowledge that I have been shown and read the "Notice of Privacy Practices" from Shawnee Vision Source.

Would you like a copy of the Notice of Privacy Practice: (circle one) Yes No

Patient Name (please print)_____

Patient/Legal Guardian Name (Please Print): _____

Patient/Legal Guardian Signature:_____ Date:_____

Financial Responsibility

We will be happy to file your insurance claim forms or take assignment from your medical/vision benefits as designated by the plan(s) of which you state the patient is a member. We will do all we can to help you receive maximum benefits. However, in the event that the plan sponsor determines that the patient is not eligible for coverage at the time of service, or makes a determination that the patient is eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by the patient and not paid by the plan sponsor at this and all future visits. By filling out and signing the information below you are acknowledging that you (the patient, parent, or legal guardian) are ultimately responsible for all and any charges incurred at this and all future visits, payable at time of service.

Collections: I understand and accept that if I have any unpaid balance with Shawnee Vision Source (SVS) and do not bring my account current, my account can be placed with an external collection agency, and all costs and expenses including reasonable attorney's fees that SVS incurs in such collection efforts will be assessed to my account and include in the balance due. Finally, I understand that this will result in endangering my credit rating on a local and/or national level by being reported to all three credit bureau's (Equifax, TransUnion, Experian).

I authorize SVS to contact me via current and any future cellular phone number(s), email address(s), or wireless device(s) regarding my delinquent account(s), any other debit I owe to SVS or receive general information from SVS. I authorize SVS and its agents, representative, and attorneys (including collection agencies) to use automated telephone dialing equipment, artificial or pre-recorded voice or text messages, and personal calls and emails, in their effort to contact me for purposes of collecting any portion of my account financial obligations which is past due. Furthermore, I understand I may withdraw my consent to call my cellular phone by submitting my request in writing to SVS or its agents on behalf of SVS. **Patient Name** (please print)_____

Patient/Legal Guardian Signature:_____ Date:_____

ALL PATIENTS UNDER 18YRS OLD MUST HAVE A GUARANTOR

Guarantor must be Legal Guardian (custody or guardianship papers must be provided if necessary)

Legal Guardian Full Name (Please Print): (First) _____ (Middle Initial) _____ (Last)_____

Legal Guardian Address: (if different from patient) _____ **Phone:** _____

Legal Guardian Full SSN: _____ **Date of Birth:** _____

Legal Guardian Employer:_____ **Work Phone:**_____

Authorization of Release of Information

In order to safeguard patient information and comply with HIPAA standards we are unable to discuss any account issues or patient records unless notified in writing by the patient (if over the age of 18 yrs old) or patient legal guardian (if patient is under the age of 18 yrs old). This includes release of prescriptions or billing information.

I hereby authorize the release of my/my guardians Medical Records from Shawnee Vision Source to the following person:

Individual Name: _____ **Relationship to Patient:** _____

Date of Birth: _____ **Last 4 of individual SSN:**_____ **(information needed to verify identity of individuals calling into our office)**

Address:_____**City:**_____ **State:**_____ **Zip:**_____

Phone Number:_____ **Email:** _____

I understand that I have the right to revoke this request in writing at any time, except to the extent that action has already been taken to comply with it. Unless revoked, this authorization will remain valid until 1 year from date of this request.

Patient/Legal Guardian Signature: _____

OFFICE USE ONLY: **Pt Name:** _____ **DOB:**_____ **Insurance: Primary/**_____**Secondary/**_____

PCP:_____ **PT occupation:**_____ **Last Vision Exam Date/Location:**_____

NEW / ESTAB / ESTAB+3yrs GLASSES / CL / CL FIT ONLY / RX CHECK/ CL CHECK/ CAT PO / LASIK PO / LASIK EVAL / MEDICAL **FILE EXAM AS:** Medical RTN Vision

IOP:_____ HT_____/WT_____ BP_____/_____ PULSE_____ DILATED? Y N Optomap Photos ? Y N

Optical: SV / PAL / FT Bifocal / FT Trifocal / SV Reading / Digital / Eyezen Plus 0 1 2 3 Poly / Trivex / 1.67 / 1.74 / AR / Transitions / Prism / Other

PAL: (VSP/Humana) Varilux Physio X Fit / Varilux Physio X / Comfort W2+ AR: Sapphire 360 / Prevencia

(Cash/Eyemed/UMR/Superior) Truclear XD / Trueclear SD / Truclear AR: Viso Pro / Viso Prevencia

(Spectera) TruClear XD / TruClear / Palz AR: Viso Pro / Viso XC

(Humana/Comp Benefits) Varilux X Design / Comfort W2+ /Comfort AR: Sapphire 360 / Prevencia

Single Vision: Essilor 360* / Truclear SV SD / Truclear SV XD No Glasses Today

CL: Sphere Fit / Toric Fit / Multifocal Fit / GP Fit / Order Trials / Order Final Supply / Try 1 Wk / Call to Order / RTC 1 Wk CL Check

Notes: