Arizona Vision Therapy Center

2312 N Rosemont Blvd St#103, Tucson, AZ 85712
(520) 886-8800 • Fax: (520) 886-8805
visiontherapy@live.com • azvisiontherapy.com

PATIENT INFORMATION

Name, Last:			Name, First:	Middle Initial:
DOB: / /	Age:	❑M ❑F	School/Occupation:	Grade:
Mailing Address:				
Email			Phone:	
How did you hear about us?			Eye Doctor:	

GUARDIAN INFORMATION (COMPLETE IF PATIENT IS A MINOR)

Mother /Guardian Name:	DOB: / /	Address (if different from above):	Phone:
Occupation:		Employer:	Work Phone:
Father /Guardian Name:	DOB: / /	Address (if different from above):	Phone:
Occupation:		Employer:	Work Phone:

IN CASE OF EMERGENCY

Name:	Relationship:	Phone:

PERMISSION TO POST PHOTOGRAPH/VIDEO/TESTIMONIAL OF PATIENT

❑Any Necessary for Office, Education or Marketing Purposes ❑Only In-Office ❑None	Initial:

PAYMENT INFORMATION

Arizona Vision Therapy Center (AVTC) is not a provider with any insurance company. I understand that I am financially responsible for all charges at/before the time of service. AVTC will provide me with invoices so I can contact my insurance company for reimbursement. By initialing, I also acknowledge that any past due balances will incur a 10% compound interest each month.	Initial:

Are you a Medicare Part B beneficiary? (Circle Yes or No and read the agreement below)

No	**Yes**	
To the best of my knowledge, I am not a Medicare Part B beneficiary. If in the future I became a beneficiary, I will be responsible for alerting Arizona Vision Therapy Center and completing this contract as soon as possible.	I understand that AVTC has opted out of the Medicare program effective on May 18, 2016 and that I cannot use my Medicare benefits for reimbursement of any services rendered. The Patient, or the patient's guardian, is responsible for any payments at the time services are rendered.	Initial:

Acknowledgement of Receipt of Notice of Privacy for Arizona Vision Therapy Center

Under the Health Insurance Portability and Accountability Act (HIPAA), I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices of AVTC. I also understand that AVTC has the right to change its Notice of Privacy Practices and that I may contact AVTC to obtain a current copy of such.	Initial:

I hereby authorize Arizona Vision Therapy Center to evaluate and treat the above patient. The above information is true to the best of my knowledge.

_____ _____ _____

Signature (Patient, Legal Guardian, Personal Representative) Printed Name Date

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Release of Information

Patient Name:_____ **Date of Birth:** _____

It is often beneficial to discuss evaluation and treatment information with everyone that is involved with a patient's health care and wellness. By signing this agreement, I agree to release examination and treatment records to the following names listed below. This authorization shall be considered valid throughout the duration of treatment.

_____

Print Patient Name *Print Parent/Guardian Name*

_____

Patient or Parent/Guardian Signature *Date*

Please list below everyone that you would like to receive evaluation and treatment information.

Optometrist	Phone/ Fax
Therapist	Phone/ Fax
Teacher/School	Phone / Fax
Pediatrician	Phone / Fax
Other	Phone / Fax
Other	Phone / Fax
Other	Phone / Fax

I wish to withhold my evaluation and treatment information from the following individuals:

Name	Relationship to patient
Name	Relationship to patient
Name	Relationship to patient

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FEE SCHEDULE

Visual Skills Exam	**$425.00**	Progress Check	**$245.00**
Contact Lens Fitting	**$ 65.00**	Follow Up	**$105.00**
Foot Bath	**$ 45.00**	Cold Red Light Laser	**$ 25.00**
Foot Bath - 5 Session Package	**$215.00**	Laser - 6 Session Package	**$135.00**
Foot Bath - 10 Session Package	**$400.00**	Laser - 12 Session Package	**$275.00**
Structural Energetic Therapy	**$50.00/30 minutes**		

Sensory Learning Program	**See Consultant (Varies as prescribed)**
Vision Therapy	**See Consultant (Varies as prescribed)**
Lens Packages/Frames	**See Optical (Varies as prescribed)**

***LENS PACKAGES DO NOT INCLUDE FOLLOW UPS** 20% off lens packages for patients enrolled in active Vision Therapy*

***50% OFF OF FIRST FOOT BATH**

If you must cancel your appointment, we ask that you give us a minimum of a **24-HOUR NOTICE** prior to your appointment. For Visual Skills Examinations a **48-HOUR NOTICE** is required.

ANY LATE CANCELLATIONS, MISSED OR NO-SHOW APPOINTMENTS WILL BE CHARGED THE COST OF THE APPOINTMENT.

Signature (Patient, Legal Guardian, Personal Representative)

Print Name and Relationship (If not Patient) / Date

All payments are due at the time of service. Payment for Visual Skills Examinations are due at the time of the Pre-test. We accept Visa, Mastercard, HSA, ESA Funds, Check, Cash and Care Credit. Any valid discounts or special offers will be applied to your invoice on the date of service. Additional tests or procedures may be required depending on the nature of the patient's present conditions.

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VISUAL SKILLS QUESTIONNAIRE

Patient Name:_____Date of Birth: _____

Date: _____ Referred By: _____

What concerns brought you here? _____

_____

Have you had any injury/accidents in the past? (ie. stitches, fell and hit head, car accident, whiplash) If so, please give the details of the injury/accident. _____

_____

Have you ever had a loss of consciousness? Yes ☐ No ☐ If yes, for how long?_____

Have you ever been in a coma? Yes ☐ No ☐ If yes, how long?_____

Have you ever been exposed to mold/toxins? (ie. Mercury fillings, lead paint, remodeled home) If so, please
explain_____

_____

DEVELOPMENTAL HISTORY

Full Term Pregnancy? ☐ Yes ☐ No If no, explain:_____

Were forceps/vacuum suction used? ☐ Yes ☐ No Was a cesarean performed? ☐ Yes ☐ No

Explain any problems prior to / during / immediately after your/your child's birth: _____

_____

At what age did you/your child experience "tummy time"? _____

At what age did you/ your child crawl (stomach on floor)? _____

At what age did you/ your child creep (stomach off floor)? _____

At what age did you/ your child walk (without support)? _____

Explain any concerns regarding your/your child's growth or development: _____

_____

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Are you currently experiencing any of the following? (Please rate Severity 0-4, 0 = none, 4 = worst)

Headaches	0	1	2	3	4
Problems Focusing	0	1	2	3	4
Double Vision	0	1	2	3	4
Eye Pain/Strain	0	1	2	3	4
Eye Fatigue	0	1	2	3	4
Words Move on Page	0	1	2	3	4
Motion/Car Sickness	0	1	2	3	4
Movement Sensitivity	0	1	2	3	4
Light Sensitivity	0	1	2	3	4
Nausea	0	1	2	3	4
Clumsiness	0	1	2	3	4
Attention Problems	0	1	2	3	4
Neck Pain/Whiplash	0	1	2	3	4
Disorientation	0	1	2	3	4
Dizziness	0	1	2	3	4
Memory Problems	0	1	2	3	4
Anxiety/Worry	0	1	2	3	4
Depression/Despair	0	1	2	3	4
Anger/Irritability	0	1	2	3	4
Overwhelm/Emotional	0	1	2	3	4
Excitement/Joy	0	1	2	3	4

How long have these symptoms been present? _____
How frequently do they occur? ☐ Always ☐ Daily ☐ Weekly ☐ Other: _____
Is there anything that makes these problems worse? _____
Is there anything that makes these problems better? _____
Is it getting better, staying the same, or worsening? _____

VISUAL HISTORY

Eye Doctor's Name: _____ Date of last visit: _____

Reason for last visit: _____ Results and recommendations: _____
_____

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MEDICAL HISTORY

Pediatrician/Primary Care Physician: _____ Date of last visit: _____

Reason for last visit: _____ Results and recommendations: _____
_____

Is there any family history of the following? (*Please check all that apply*)

	Patient	Family	Who		Patient	Family	Who
High blood pressure	☐	☐	____	Glaucoma	☐	☐	____
Diabetes	☐	☐	____	Cataracts	☐	☐	____
Thyroid condition	☐	☐	____	Blindness	☐	☐	____
Multiple Sclerosis	☐	☐	____	Strabismus	☐	☐	____
Brain Tumor	☐	☐	____	Amblyopia	☐	☐	____
Stroke	☐	☐	____	Traumatic brain injury	☐	☐	____

List any major injuries or illnesses (ear infections, asthma, hay fever, allergies, car accidents, falls, etc.):
_____
_____

List treatments for above injuries or illnesses: _____
_____
_____

Current medications, including vitamins and supplements: _____
_____
_____

List any neurological, psychological, or occupational therapy, evaluations, etc. (by whom, results, and recommendations): _____
_____

Is there any drug usage, alcohol usage or smoking in the household? If so, please specify below:_____

_____

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SCHOOL/WORK

List any special tutoring, therapy, and/or recommendations for school/work:_____
_____

FAMILY AND HOME (*Please list the names and birth dates of your family*)

Sibling:_____ DOB:_____

Sibling:_____ DOB: _____

Sibling: _____ DOB: _____

Please indicate which adult you/your child lives with: ☐ Mother ☐ Father ☐ Both ☐ Self

List any traumatic family situations (such as divorce, parental loss, separation, severe parental illness): _____

Is family life stable at this time? ☐ Yes ☐ No If no, please explain: _____

LIFESTYLE

Explain how your/your child's vision interferes with daily living (i.e.: home, work, hobbies, etc.):
_____
_____

What do you hope a Vision Therapy Program can do for you/your child? _____
_____
_____

List any other information you feel would be important in the patient's treatment: _____
_____
_____

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Have you or anyone else ever noticed the following symptoms with you/your child over the last few months? (*Please check all that apply*)

☐ Frequent blinking
☐ Frequent eye rubbing
☐ Closing or covering one eye
☐ Eye turns in, out, up, or down
☐ Eyes ache, pull or tug
☐ Flashes of light or shadow
☐ Difficulty moving/turning eyes
☐ Difficulty changing focus
☐ Difficulty copying from board
☐ Avoids reading
☐ Moves head when reading
☐ Fatigues with near tasks
☐ Poor reading comprehension
☐ Vocalizes when reading silently
☐ Reads slowly
☐ Loses place easily while reading
☐ Skips, re-reads or omits words/lines
☐ Confuses words with same end and beginning
☐ Problem recognizing same word on different page
☐ Reverses letters or words
☐ Confuses right and left
☐ Poor recall of visual tasks
☐ Better recall for hearing than seeing
☐ Knows answers but tests poorly
☐ School performance below potential
☐ Bothered by fluorescent lights
☐ Bothered by headlights
☐ Bothered by screens
☐ Bothered by noises
☐ Bothered by touch
☐ Bothered by movement in environment
☐ Bothered by patterned wallpaper/carpets
☐ Difficulty with peripheral vision
☐ Reduced depth perception
☐ Dislikes heights
☐ Awkward/poor balance
☐ Difficulty following directions
☐ Confusion/disorientation
☐ Gets lost often
☐ Overwhelmed easily
☐ Bumps into things
☐ Drops/spills things frequently
☐ Dislikes/avoids sports
☐ Difficulty catching/hitting a ball
☐ Difficulty coordinating body movements
☐ Writes or prints poorly
☐ Writes neatly but slowly
☐ Speaking/responding slowly
☐ Difficulty communicating
☐ Slurred speech