



PATIENT INFORMATION

| | | | | | |
|----------------------------|------|---|--------------------|-----------------|--------|
| Name, Last: | | Name, First: | | Middle Initial: | |
| DOB: / / | Age: | <input type="checkbox"/> M <input type="checkbox"/> 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: (if different from above) |
| 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

| | | | |
|--|---|-------------------------------|----------|
| <input type="checkbox"/> Any Necessary for Office, Education or Marketing Purposes | <input type="checkbox"/> Only In-Office | <input type="checkbox"/> 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 | Initial: |
|--|--|----------|
| To the best of my knowledge, I am not a Medicare Part B beneficiary. If in the future I become 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. | |

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



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 treatment records to the following names listed below. This authorization shall be considered valid throughout the duration of treatment.

Signature (Patient, Legal Guardian, Personal Representative)

Date

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

Optometrist

Phone/ Fax or Email

Therapist

Phone/ Fax or Email

Teacher/School

Phone / Fax or Email

Pediatrician

Phone / Fax or Email

Other (Relationship to Patient)

Phone / Fax or Email

Other (Relationship to Patient)

Phone / Fax or Email

Other (Relationship to Patient)

Phone / Fax or Email

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



FEE SCHEDULE

| | | | |
|---|-----------------|----------------------------|-----------------------|
| Visual Skills Exam | \$650.00 | Progress Check | \$245.00 |
| Established Exam | \$350.00 | Follow Up | \$125.00 |
| Foot Bath (50% off 1 st one) | \$ 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 |
| Contact Lens Fitting | \$ 65.00 | SET | \$50.00/30 min |
| Neuro Brain Map | \$185.00 | Neurofeedback Session | \$100.00 |

Sensory Learning Program / Vision Therapy / Lens Pkg / Frames (Varies as prescribed)

This office specializes in developmental and neurocognitive conditions. Even though we screen for gross pathology we still strongly recommend an annual examination with your regular eye doctor to ensure that your ocular eye health is stable and free from any ocular pathology.

Dilation is not typically done in this office. The exception would be if certain risk factors are present at the time of the examination. These risk factors may include diabetes, retinal detachment, uncontrolled blood pressure and high cholesterol. **If dilation is necessary, the fee is \$30.00.**

After dilation, your vision may be blurry and you will be sensitive to bright light for up to 24 hours. It is strongly recommended that you do not drive if you are dilated.

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

If you must cancel your appointment, we ask that you give us a minimum of a **24-HOUR NOTICE** prior to your appointment.

ANY LATE CANCELLATIONS, MISSED, OR NO-SHOW APPOINTMENTS WILL BE CHARGED \$105.

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.



VISUAL SKILLS QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Date: _____ Referred By: _____

Please answer all questions from the patient's point of view:

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? _____



Please answer all questions from the patient's point of view:

7. Did you like school? Why/why not?

8. Did you like to read? Why/why not?

9. Did you like physical education (PE)? Why/why not?

10. Have you had any traumas/infections/health conditions in the past? (i.e.: traumas from death, falls, car accidents, whiplash, broken bones, etc.)
For each incident/condition, please write when it occurred, what body parts were affected, how it was treated, if the treatment worked well, current symptoms caused by it, and any other important details:

11. Have you ever been exposed to mold/toxins? (i.e.: mercury fillings, lead paint, remodeled home)
For each incident, write when it started, how long it was present, what has been done to help it, was the treatment successful, current symptoms caused by it, and any other important details:



Please answer all questions from the patient's point of view:

Have you or anyone else ever noticed the following signs/symptoms in you over the last few months?

(Please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Frequent blinking | <input type="checkbox"/> Bothered by fluorescent lights |
| <input type="checkbox"/> Frequent eye rubbing | <input type="checkbox"/> Bothered by headlights |
| <input type="checkbox"/> Closing or covering one eye | <input type="checkbox"/> Bothered by screens |
| <input type="checkbox"/> Eye turns in, out, up, or down | <input type="checkbox"/> Bothered by noises |
| <input type="checkbox"/> Eyes ache, pull or tug | <input type="checkbox"/> Bothered by touch |
| <input type="checkbox"/> Flashes of light or shadow | <input type="checkbox"/> Bothered by movement in environment |
| <input type="checkbox"/> Difficulty moving/turning eyes | <input type="checkbox"/> Bothered by patterned wallpaper/carpets |
| <input type="checkbox"/> Difficulty changing focus | <input type="checkbox"/> Difficulty with peripheral vision |
| <input type="checkbox"/> Difficulty copying from board | <input type="checkbox"/> Reduced depth perception |
| <input type="checkbox"/> Avoids reading | <input type="checkbox"/> Dislikes heights |
| <input type="checkbox"/> Moves head when reading | <input type="checkbox"/> Awkward/poor balance |
| <input type="checkbox"/> Fatigues with near tasks | <input type="checkbox"/> Difficulty following directions |
| <input type="checkbox"/> Poor reading comprehension | <input type="checkbox"/> Confusion/disorientation |
| <input type="checkbox"/> Vocalizes when reading silently | <input type="checkbox"/> Gets lost often |
| <input type="checkbox"/> Reads slowly | <input type="checkbox"/> Overwhelmed easily |
| <input type="checkbox"/> Loses place easily while reading | <input type="checkbox"/> Bumps into things |
| <input type="checkbox"/> Skips, re-reads or omits words/lines | <input type="checkbox"/> Drops/spills things frequently |
| <input type="checkbox"/> Confuses words with same end and beginning | <input type="checkbox"/> Dislikes/avoids sports |
| <input type="checkbox"/> Problem recognizing same word on different page | <input type="checkbox"/> Difficulty catching/hitting a ball |
| <input type="checkbox"/> Reverses letters or words | <input type="checkbox"/> Difficulty coordinating body movements |
| <input type="checkbox"/> Confuses right and left | <input type="checkbox"/> Writes or prints poorly |
| <input type="checkbox"/> Poor recall of visual tasks | <input type="checkbox"/> Writes neatly but slowly |
| <input type="checkbox"/> Better recall for hearing than seeing | <input type="checkbox"/> Speaking/responding slowly |
| <input type="checkbox"/> Knows answers but tests poorly | <input type="checkbox"/> Difficulty communicating |
| <input type="checkbox"/> School performance below potential | <input type="checkbox"/> Slurred speech |
| | <input type="checkbox"/> None of the above |



STRUCTURAL ENERGETIC THERAPY (SET)

We strongly recommend SET before the first appointment with the doctor. Since our vision, brain and body are all connected, completing SET first will begin to correct imbalances within the body which in turn helps the doctor complete the examination in the most efficient manner possible.

Your SET therapist will apply gentle pressure and movements to your cranium to ensure the cranial structure is optimally balanced. Once imbalances are corrected, it can help decrease physical pain, improve body function and enhance overall well-being, supporting long term health and vitality.

Please check the box if any of the following conditions apply to you:

- Blood thinners
- Pregnant (6-9 months)
- Recent brain surgery (less than 6 months)
- Shunts in ventricle to abdomen
- Recent concussion or TBI (less than 3 weeks)
- Plates crossing midline of cranium
- Detached retina (less than 4 months after surgery)
- Chiari syndrome (level 3 and 4)
- Recent epidural or cortisone shot in spinal column
- Carotid artery stents
- None of the above

Appointment Details and Pricing:

- **Children (16 and under) \$50.00** for a 30-minute session
- **Adults \$100.00** for a 60-minute session

Please check one of the following boxes below:

- I would like to schedule a SET appointment before seeing the doctor.
- I do not want to schedule a SET appointment before seeing the doctor. (**Choosing to decline this treatment before seeing the doctor may extend the amount of time needed to heal your condition.**)

Signature (*Patient, Legal Guardian, Personal Representative*)



Brain Region Localization Form

INSTRUCTIONS:

The purpose of this questionnaire is to identify difficulties that you may be experiencing. Please answer every question, do not skip any questions. Follow the 0 to 4 key, and select which best fits for all of your answers.

KEY:

- 0 = I never have symptoms (0% of the time)
- 1 = I rarely have symptoms (Less than 25% of the time)
- 2 = I often have symptoms (Half of the time)
- 3 = I frequently have symptoms (75% of the time)
- 4 = I always have symptoms (100% of the time)

NAME: _____

DATE: _____

| Frontal lobe Prefrontal, Dorsolateral and Orbitofrontal (Areas 9, 10, 11, and 12) | | Level | Frontal Lobe Precentral and Supplementary Motor Areas (Area 4 and 6) | | Level |
|---|--|-----------|---|--|-----------|
| 1. | Difficulty with restraint and controlling impulses or desires | 0 1 2 3 4 | 18. | Initiating movements with your arm or leg has become more difficult | 0 1 2 3 4 |
| 2. | Emotional instability (lability) | 0 1 2 3 4 | 19. | Feeling of arm or leg heaviness, especially when tired | 0 1 2 3 4 |
| 3. | Difficulty planning and organizing | 0 1 2 3 4 | 20. | Increased muscle tightness in your arm or leg | 0 1 2 3 4 |
| 4. | Difficulty making decisions | 0 1 2 3 4 | 21. | Reduced muscle endurance in your arm or leg | 0 1 2 3 4 |
| 5. | Lack of motivation, enthusiasm, interest and drive (apathetic) | 0 1 2 3 4 | 22. | Noticeable difference in your muscle function or strength from one side to the other | 0 1 2 3 4 |
| 6. | Difficulty getting a sound or melody out of your thoughts (Perseveration) | 0 1 2 3 4 | 23. | Noticeable difference in your muscle tightness from one side to the other | 0 1 2 3 4 |
| 7. | Constantly repeat events or thoughts with difficulty letting go | 0 1 2 3 4 | Frontal Lobe Broca's Motor Speech Area (Area 44 and 45) | | Level |
| 8. | Difficulty initiating and finishing tasks | 0 1 2 3 4 | 24. | Difficulty producing words verbally, especially when fatigued | 0 1 2 3 4 |
| 9. | Episodes of depression | 0 1 2 3 4 | 25. | Find the actual act of speaking difficult at times | 0 1 2 3 4 |
| 10. | Mental fatigue | 0 1 2 3 4 | 26. | Notice word pronunciation and speaking fluency change at times | 0 1 2 3 4 |
| 11. | Decrease in attention span | 0 1 2 3 4 | Parietal Somatosensory Area and Parietal Superior Lobule (Areas 3,1,2 and 7) | | Level |
| 12. | Difficulty staying focused and concentrating for extended periods of time | 0 1 2 3 4 | 27. | Difficulty in perception of position of limbs | 0 1 2 3 4 |
| 13. | Difficulty with creativity, imagination, and intuition R | 0 1 2 3 4 | 28. | Difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall | 0 1 2 3 4 |
| 14. | Difficulty in appreciating art and music R | 0 1 2 3 4 | 29. | Frequently bumping body or limbs into the wall or objects accidentally | 0 1 2 3 4 |
| 15. | Difficulty with analytical thought L | 0 1 2 3 4 | 30. | Reoccurring injury in the same body part or side of the body | 0 1 2 3 4 |
| 16. | Difficulty with math, number skills and time consciousness L | 0 1 2 3 4 | 31. | Hypersensitivities to touch or pain perception | 0 1 2 3 4 |
| 17. | Difficulty taking ideas, actions, and words and putting them in a linear sequence L | 0 1 2 3 4 | | | |



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| Parietal Inferior Lobule (Area 39 and 40) | | Level | Medial Temporal lobe and Hippocampus | | Level |
|--|--|----------------------------|--|--|-----------|
| 32. | Right/left confusion <input type="checkbox"/> L | 0 1 2 3 4 | 49. | Memory less efficient | 0 1 2 3 4 |
| 33. | Difficulty with math calculations <input type="checkbox"/> L | 0 1 2 3 4 | 50. | Memory loss that impacts daily activities | 0 1 2 3 4 |
| 34. | Difficulty finding words <input type="checkbox"/> L | 0 1 2 3 4 | 51. | Confusion about dates, the passage of time, or place | 0 1 2 3 4 |
| 35. | Difficulty with writing <input type="checkbox"/> L | 0 1 2 3 4 | 52. | Difficulty remembering events | 0 1 2 3 4 |
| 36. | Difficulty recognizing symbols or shapes <input type="checkbox"/> R | 0 1 2 3 4 | 53. | Misplacement of things and difficulty retracing steps | 0 1 2 3 4 |
| 37. | Difficulty with simple drawings <input type="checkbox"/> R | 0 1 2 3 4 | 54. | Difficulty with memory of locations (addresses) <input type="checkbox"/> R | 0 1 2 3 4 |
| 38. | Difficulty interpreting maps <input type="checkbox"/> R | 0 1 2 3 4 | 55. | Difficulty with visual memory <input type="checkbox"/> R | 0 1 2 3 4 |
| Temporal Lobe Auditory Cortex (Areas 41, 42) | | Level | 56. | Always forgetting where you put items such as keys, wallet, phone, etc. <input type="checkbox"/> R | 0 1 2 3 4 |
| 39. | Reduced function in overall hearing | 0 1 2 3 4 | 57. | Difficulty remembering faces <input type="checkbox"/> R | 0 1 2 3 4 |
| 40. | Difficulty interpreting speech with background or scatter noise | 0 1 2 3 4 | 58. | Difficulty remembering names with faces <input type="checkbox"/> L | 0 1 2 3 4 |
| 41. | Difficulty comprehending language without perfect pronunciation | 0 1 2 3 4 | 59. | Difficulty with remembering words <input type="checkbox"/> L | 0 1 2 3 4 |
| 42. | Need to look at someone's mouth when they are speaking to understand what they are saying | 0 1 2 3 4 | 60. | Difficulty remembering numbers <input type="checkbox"/> L | 0 1 2 3 4 |
| 43. | Difficulty in localizing sound | 0 1 2 3 4 | 61. | Difficulty remembering to stay or be on time (reduced left) <input type="checkbox"/> L | 0 1 2 3 4 |
| 44. | Dislike of left predictable rhythmic, repeated tempo and beat music <input type="checkbox"/> L | 0 1 2 3 4 | Occipital Lobe (Area, 17, 18, and 19) | | Level |
| 45. | Dislike of non-predictable rhythmic with multiple instruments <input type="checkbox"/> R | 0 1 2 3 4 | 62. | Difficulty in discriminating similar shades of color | 0 1 2 3 4 |
| 46. | Noticeable ear preference when using your phone | right, left, no preference | 63. | Dullness of colors in visual field | 0 1 2 3 4 |
| Temporal Lobe Auditory Association Cortex (Area 22) | | Level | 64. | Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach out for objects | 0 1 2 3 4 |
| 47. | Difficulty comprehending meaning of spoken words <input type="checkbox"/> L | 0 1 2 3 4 | 66. | Floater or halos in visual field | 0 1 2 3 4 |
| 48. | Tend toward monotone speech without fluctuations or emotions <input type="checkbox"/> R | 0 1 2 3 4 | | | |



Brain Region Localization Form

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| Cerebellum - Spinocerebellum | | Level | 82. | Cramping of hands when writing | 0 1 2 3 4 |
|----------------------------------|---|-----------|--|--|-----------|
| 67. | Difficulty with balance, or balance that is worse on one side | 0 1 2 3 4 | 83. | A stooped posture when walking | 0 1 2 3 4 |
| 68. | A need to hold the handrail or watch each step carefully when going down stairs | 0 1 2 3 4 | 84. | Voice has become softer | 0 1 2 3 4 |
| 69. | Feeling unsteady and prone to falling in the dark | 0 1 2 3 4 | 85. | Facial expression changed leading people to frequently ask if you are upset or angry | 0 1 2 3 4 |
| 70. | Proness to sway to one side when walking or standing | 0 1 2 3 4 | Basal Ganglia Indirect Pathway | | Level |
| Cerebellum - Cerebrocerebellum | | Level | 86. | Uncontrollable muscle movements | 0 1 2 3 4 |
| 71. | Recent clumsiness in hands | 0 1 2 3 4 | 87. | Intense need to clear your throat regularly or contract a group of muscles | 0 1 2 3 4 |
| 72. | Recent clumsiness in feet or frequent tripping | 0 1 2 3 4 | 88. | Obsessive compulsive tendencies | 0 1 2 3 4 |
| 73. | A slight hand shake when reaching for something at the end of movement | 0 1 2 3 4 | 89. | Constant nervousness and restless mind | 0 1 2 3 4 |
| Cerebellum - Vestibulocerebellum | | Level | Autonomic Reduced Parasympathetic Activity | | Level |
| 74. | Episodes of dizziness or disorientation | 0 1 2 3 4 | 90. | Dry mouth or eyes | 0 1 2 3 4 |
| 75. | Back muscles that tire quickly when standing or walking | 0 1 2 3 4 | 91. | Difficulty swallowing supplements or large bites of food | 0 1 2 3 4 |
| 76. | Chronic neck or back muscle tightness | 0 1 2 3 4 | 92. | Slow bowel movements and tendency for constipation | 0 1 2 3 4 |
| 77. | Nausea, car sickness, or sea sickness | 0 1 2 3 4 | 93. | Chronic digestive complaints | 0 1 2 3 4 |
| 78. | Feeling of disorientation or shifting of the environment | 0 1 2 3 4 | 94. | Bowel or bladder incontinence resulting in staining your underwear | 0 1 2 3 4 |
| 79. | Crowded places cause anxiety | 0 1 2 3 4 | Autonomic Increased Sympathetic Activity | | Level |
| Basal Ganglia Direct Pathway | | Level | 95. | Tendency for anxiety | 0 1 2 3 4 |
| 80. | Slowness in movements | 0 1 2 3 4 | 96. | Easily startled | 0 1 2 3 4 |
| 81. | Stiffness in your muscles (not joints) that goes away when you move | 0 1 2 3 4 | 97. | Difficulty relaxing | 0 1 2 3 4 |
| | | | 98. | Sensitive to bright or flashing lights | 0 1 2 3 4 |
| | | | 99. | Episodes of racing heart | 0 1 2 3 4 |
| | | | 100. | Difficulty sleeping | 0 1 2 3 4 |