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

Last, Name:			Name, First:	Middle Initial:
DOB: / /	Age:	☐M ☐F	School/Occupation:	Grade:
Mailing Address:				
Email			Phone:	
Referred By:			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 15% compound interest each month.	Initial:

Are you a Medicare Part B beneficiary? (Check 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.

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:

The above information is true to the best of my knowledge.

_____ _____ _____

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

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I hereby authorize Arizona Vision Therapy Center to treat the patient stated above:

_____

Patient or Parent/Guardian Signature *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 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

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

Name	Relationship to patient
Name	Relationship to patient

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EXAM SERVICES

Visual Skills Exam:	**$375.00**	Contact Lens Fitting:	**$60.00**
Sensory Learning Program (Pre-test):	**$260.00**	Follow-Up:	**$75.00**
Regular Eye Exam:	**$190.00**	Dilation Fee:	**$20.00**

Our office does have a strict late cancellation/no show policy. If you must cancel your appointment, we ask that you give us a 48-hour notice prior to your appointment. Any late cancellation or no show appointments will be charged a $65 fee.

****(Follow/Ups are NOT included with Visual Skills and Regular Eye Exams) ****

_____ _____

Signature (Patient, Legal Guardian, Personal Representative) Print Name and Relationship (If not Patient) / Date

**Payment is due at time of service. If applicable discounts/special offers will be applied to your service. Additional tests or procedures may be required depending on the nature of the patient's present conditions.

Regular Eye Exam
Patient History Questionnaire

Patient Name:_____**DOB:**_____**Today's Date:** _____

What concerns brought you here? _____
_____
_____
_____

Signs/Symptoms - Check all that apply to you:

- ☐ Distance vision problems (using glasses)
- ☐ Reading/computer problems (using glasses)
- ☐ Double vision
- ☐ Flashing lights (that appear out of nowhere)
- ☐ Floaters
- ☐ Headaches after near work (reading, using computer, etc.)
- ☐ Fatigue after near work (reading, using computer, etc.)
- ☐ Eye turn (In / Out / Up / Down)
- ☐ Unusual visual demands:
  _____

Medical History – Check all that apply to you:

- ☐ Ears / Nose / Throat (Hearing / Sinus)
- ☐ Heart / Circulation (Blood Pressure / Cholesterol)
- ☐ Lungs (Emphysema / Problems breathing)
- ☐ Gastrointestinal (GERD / Irritable bowel syndrome)
- ☐ Kidney / Urinary (UTI / Stones)
- ☐ Endocrine (Diabetes /Thyroid / Anxiety)
- ☐ Skin (Rash / Eczema / Psoriasis)
- ☐ Blood (Anemia / Hypercoagulation)
- ☐ Muscle / Joint (Arthritis / Injury Prone)
- ☐ Brain / Spinal cord (Cyst / Tumor / Injury)
- ☐ Cancer
- ☐ Pregnant
- ☐ Allergies:_____
- ☐ Other systemic problem(s):_____

Ocular History – Check all that apply to you:

- ☐ History of eye trauma / surgery
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Amblyopia ("Lazy Eye")
- ☐ Other eye problem(s): _____

Family History:

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Diabetes
- ☐ Other eye disease: _____
- ☐ Heart conditions

Past Treatments: _____

_____

_____

Current medications including supplements: _____

_____

_____

Dilation: Dilation is necessary about every 2-3 years to assess the health of the eye. Certain risk factors like diabetes, retinal detachment, uncontrolled blood pressure, high cholesterol, and high prescription glasses, may require you to be dilated more frequently. The fee is $20.00.

After dilation your vision may be blurry and you will be sensitive to bright light. These effects usually last from 4 to 24 hours; for children sometimes longer. It is recommended that you not drive if you are dilated.

- ☐ I would like to have dilation as part of my routine examination and accept that it is not
- ☐ I decline dilation today.

Privacy Notice:

- ☐ I acknowledge that I have received and reviewed the Notice of Privacy Practices.

Contact Fitting & Follow-up Policy/Terms of Service: There will be a $60.00 fee for all contact fittings. Please be advised that a contact lens examination may require additional appointments (at no charge up to 60 days from original appointment) before a contact lens prescription is released.

There will be a $65.00 fee for all other follow-up appointments.

The above information is true to the best of my knowledge.

_____

Patient/Parent/Legal Guardian Signature