Arizona Vision Therapy Center

2312 N Rosemont Blvd #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:		
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 10% 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.

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BRAIN INJURY QUESTIONNAIRE

Patient Name:_____ Date of Birth: _____

Date: _____

INJURY HISTORY:

Details of injury/accident:

Was there loss of consciousness? Yes ☐ No ☐ If yes, for how long? _____
Was there a coma? Yes ☐ No ☐ If yes, how long? _____

SYMPTOMS OF ACCIDENT/INJURY: (circle all that apply)

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

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

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DEVELOPMENTAL HISTORY (Status prior to injury):

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

List any concerns regarding development as a baby/child (to include coordination, speech, reading, etc.):

MEDICAL HISTORY

Is there any history of the following? (please check if there is a history)

	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 other injuries or illnesses (ear infections, asthma, high fevers, allergies, car accidents, falls, etc):

List treatments that were given for the above injuries or illnesses:

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List current medications, including vitamins and supplements:

VISUAL HISTORY

Eye doctor's name: _____

Date of last visit: _____

Reason for last visit: _____

DO YOU EXPERIENCE ANY OF THE FOLLOWING?

	Yes	No	Prior to Injury
One eye turns in, out, up, or down	☐	☐	☐
Movements around you are bothersome	☐	☐	☐
Fluorescent light is bothersome	☐	☐	☐
Patterned wallpaper/ carpets bother you	☐	☐	☐
Lose place often when reading	☐	☐	☐
Words jump or move around when reading	☐	☐	☐
Discomfort when reading	☐	☐	☐
Loss of concentration when doing close work	☐	☐	☐
Orient writing/ drawing poorly on page	☐	☐	☐
Squinting, covering, or closing one eye	☐	☐	☐
Head tilts during desk work	☐	☐	☐
Avoid reading or writing	☐	☐	☐
Objects jump in and out of field of view	☐	☐	☐
Reduced depth perception	☐	☐	☐
Tunnel vision/ Loss of visual field	☐	☐	☐
Flashes of light	☐	☐	☐
Difficulty following a series of directions	☐	☐	☐
Dislike heights	☐	☐	☐
Awkward, poor balance	☐	☐	☐
Gets lost often	☐	☐	☐

LIFESTYLE

How does your vision interfere with activities of daily living?

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What activities comprise the majority of daily life since the injury?

What activities can you no longer engage in due to the visual difficulties?

What are other changes/limitations in daily life that can be attributed to the injury?

What do you hope a Visual Rehabilitation Program can do for you?

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

(Print Name)

(Signature)

Date