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.

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Visual Skills Questionnaire

Patient Name:____Date: __________________________

Date of Birth: __________________________ Referred By: ____________________

WHAT CONCERNS BROUGHT YOU HERE?

____

____

HAVE ANY OF THE FOLLOWING BEEN REPORTED? (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 problems/ difficulties been observed? _________________________________

How frequently does it occur? ☐Always ☐Daily ☐Weekly ☐Monthly ☐Other: _______________

Is there anything that makes this problem better? ____

Is there anything that makes this problem worse? ____

Is it getting better, staying the same, or worsening? ______________________________________

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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: ______________________________

____

VISUAL HISTORY

Eye Doctor's Name:______________________________Date of last visit: ____________________

Reason last visit:______________________________Results and recommendations: ____________________

____

MEDICAL HISTORY

Pediatrician/ Primary Care Physician:______________________________Date of last visit: ____________________

Reason for last visit: ______________________________

Results and recommendations: ______________________________

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

	Patient	Family	Who?		Patient	Family	Who?
Hypertension	☐	☐	_______	Amblyopia (lazy eye)	☐	☐	_______
Diabetes	☐	☐	_______	Strabismus (eye turn)	☐	☐	_______
Glaucoma	☐	☐	_______	Learning Disability	☐	☐	_______
Multiple Sclerosis	☐	☐	_______	ADD/ADHD	☐	☐	_______
Epilepsy/Seizures	☐	☐	_______	Autism	☐	☐	_______

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

____

____

List treatments for above injuries or illnesses: ____

____

____

Medications currently using, including vitamins and supplements: ______________________________

____

____

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

____

____

HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWI NG SYMPTOMS WITH YOU/YOUR CHILD? (please check all that apply)

- ☐ Frequent Blinking
- ☐ Frequent Eye Rubbing
- ☐ Frowning with near work
- ☐ Closing or Covering one eye
- ☐ Squints When Reading
- ☐ Eye turns in, out, up, or down
- ☐ Bothered by the light
- ☐ Tilts head when reading and/or writing
- ☐ Head close to paper
- ☐ Moves head when reading
- ☐ Uses finger when reading
- ☐ Avoids Reading
- ☐ Fatigues with near tasks
- ☐ Poor reading comprehension
- ☐ Comprehensive lessens with time
- ☐ Reads slowly
- ☐ Loses place easily with reading
- ☐ Skips, rereads, or omits words
- ☐ Re-reads entire lines of print
- ☐ Confuses words with same end and beginning
- ☐ Problem recognizing same word on different page
- ☐ Words move on page
- ☐ Reports confusion of what is seen
- ☐ Reverses letters or words
- ☐ Confuses right and left
- ☐ Difficulty with memory
- ☐ Poor recall of visual tasks
- ☐ Better recall for hearing than seeing
- ☐ Responds better orally than by writing
- ☐ Knows answers but tests poorly
- ☐ Short attention span/ loses interest
- ☐ Vocalizes when reading silently
- ☐ School performance below potential
- ☐ Difficulty copy from Chalkboard/smartboards
- ☐ Writes/prints poorly
- ☐ Writes neatly but slowly
- ☐ Awkward or immature pencil grip
- ☐ Frequent Erasures
- ☐ Poor large motor coordination
- ☐ Poor fine motor coordination
- ☐ Dislikes/ avoids sports
- ☐ Difficulty catching/ hitting a ball

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SCHOOL

Is school enjoyable? ☐ Yes ☐ No Do you/your child read for pleasure? ☐ Yes ☐ No

Specifically describe any school difficulties: ______________________________

____

List any special tutoring, therapy, and/or remedial assistance: ______________________________

____

Overall schoolwork is: above average ☐ average ☐ below average ☐

Subjects above average: ______________________________

Subjects below average: ______________________________

How much time on average is spent each day on homework assignments? ______________________________

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:

____

____