Maumee Center for Eyecare

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DEAR PARENTS:
Your child's vision develops in conjunction with such other functions as walking and talking and is affected by certain illness as well his/her family history. Therefore, your thorough answers to this form will aid us in determining how your child's vision has developed as well as permitting us to utilize all of the office time for a complete optometric examination.

Child's full name:_____ Nickname:_____
Address_____City_____Zip_____
Home Ph. #_____ Birth date_____ Age now _____ Grade_____
School_____ Teacher's name_____
Parents' names_____
Step-parents/Guardian (if applicable)_____
Work Ph. #_____ Cell Ph. # _____
Parents' occupations: _____
Parent's email Address:_____

PRESENT SITUATION:
Does your child seem to have any visual difficulty?_____
_____

Does your child experience any of the following:

a) headaches	__Yes	__No	When?_____
b) blurred vision	__Yes	__No	When?_____
c) double vision	__Yes	__No	When?_____
d) eyes "hurt or seem tired	__Yes	__No	When?_____

OCULAR HISTORY:

a)__ holding reading close
b)__ uses fingers when reading
c)__ reverse words
d)__ skips words
e)__ closes or covers one eye
f)__ frowning or squinting
g)__ eyes frequently reddened
h)__ frequent styes
i)__ excessive eye rubbing
j)__ getting lost in books
k)__ tilting head when reading
l)__ bumping into objects
m)__ poor general coordination
n)__ large pupils in bright lights
o)__ bothered by light
p)__ "car sickness"

ACADEMIC HISTORY:

Age at time of entrance into Kindergarten _____
Age at time of entrance into First Grade _____
Child likes school _____yes _____no _____unknown
Child likes teacher _____yes _____no _____unknown
Repeated grade/s_____

Explain any difficulty with school_____

_____

List subjects, which seem difficult for your child_____

_____

List reasons for which child is having remedial work_____

_____

Child likes to read? ____Yes ____No ____Sometimes

DEVELOPMENTAL HISTORY:

Pregnancy: ____ full term ____ premature
Birth: ____normal ____ caesarean
Complications before, during or immediately following delivery: _____

_____

Crawled: ____yes ____no On all fours: ____yes ____no
Walked at age: ____months ____ unknown
Speech: First words at age ____ ____ sentences ____unknown
When fatigued child: ____ sags ____ becomes irritable ____becomes excited

MEDICAL HISTORY:

List all past illnesses and significant injuries: _____

_____

_____

MEDICATIONS:

List all current medications:_____

_____

_____

HEALTH AT PRESENT:

___ good ____ fair ____ poor

PREVIOUS VISUAL HISTORY:

Examination date: _____ Results: _____

List all family members who have had visual attention and why: _____

_____

List any unusual family eye conditions: _____

_____

Give a brief thumbnail description of child's personality: _____

_____

INSURANCE INFORMATION: We will need to make copies of your insurance cards.

Major Medical _____ Policy #/member name_____

Secondary Ins._____ Policy #/member name_____

Vision Ins. _____ Policy #/member name_____
DOB and SSN of policyholder _____
How did you hear about us?_____
Referred by: _____
Thank you

MAUMEE CENTER FOR EYECARE
VISION THERAPY INC.
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STUDENT_____ **D.O.B.**_____

Behavioral Indicators of Vision Performance Difficulties

VISUAL

_____ Difficulty with or avoidance of tasks requiring concentration, memory, reading or problem solving
_____ Poor memory or concentration, trouble with spelling, vocabulary and grammar
_____ Inability to complete work during a given time frame
_____ Complains of headache associated with near work
_____ Complains of double vision or of blurry vision (far or near)
_____ Covers or closes one eye when reading or doing near tasks
_____ Complains of discomfort or inability to learn tasks demanding consistent attention to fine detail
_____ Tilts head extremely or works to one side of desk
_____ Either eye turns in or out
_____ Rubs eyes or forehead frequently

VISUAL-MOTOR

_____ Poor physical or athletic performance (particularly poor spatial awareness)
_____ Holds reading material very close to face
_____ Writes in small, cramped style
_____ Makes frequent errors in copying
_____ Complains of words or letters jumping around
_____ Loss of place while reading
_____ Uses finger to keep place while reading
_____ Handwriting is sloppy
_____ Easily frustrated trying to draw figures

READING/LANGUAGE

_____ Reverses letters or words
_____ Omits letters/words when reading or writing
_____ Poor spelling
_____ Tires easily when reading
_____ Performs below ability level for obvious reason

ATTENTION

_____ Trouble sitting still, fidgets frequently
_____ Poor attention to reading
_____ Responds to directions poorly
_____ Behavior problems (particularly those related to frustration in the learning environment)
_____ Displays tiredness or lethargy during the school day
_____ Indifference to classroom and/or academic performance
_____ Trouble remembering or relating to material that is read

TEACHER_____ **GRADE**_____
SCHOOL_____
PHONE_____

MAUMEE CENTER FOR EYECARE
PATIENT FINANCIAL INFORMATION SHEET

Name of Patient:_____ **DOB**_____

Name of Insured:_____ **DOB**_____

If NO Insurance Card is Available please supply the Insurance Carrier and ID#
Name of Insurance Carrier:_____

ID#_____ **Policy#**_____

Insurance Card Copied:_____Yes _____No _____No Card

Authorization and Release:

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____
Signature of patient or parent if minor Date

HIPAA PRIVACY PRACTICE ACKNOWLEDGEMENT

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such care to third party payers and/or other healthcare practitioners.

I accept release of records:

_____ _____
Signature **Date**

I decline release of records:

_____ _____
Signature **Date**

Office Policy
Maumee Center for EyeCare

New patients and current patients:

Thank you for choosing us as your vision care provider. We are committed to your treatment being successful. Please understand that payment of services is considered a part of your treatment. This letter is to help us, as well as our patients understand our office and financial policies which we require you to read and sign prior to any future treatment. In order for us to keep our fees lower we need to obtain control of very costly monthly billing.

All patients must complete our Information and Insurance form before seeing the doctor.

Full payment is due at time of service unless otherwise arranged prior. We accept cash, checks, Visa, MasterCard & Discover.

Invoices are due upon receipt. If your account must be sent for collection activity, you may be asked to seek vision care elsewhere. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonably attorneys' fees, we incur in such collection efforts.

Usual and Customary Rates:

I understand it is my responsibility to present the correct medical and vision insurance cards. Any additional cost not covered by insurance is my responsibility. **Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. They vary from one insurance company to another.**

Minor Patients:

The adult accompanying a minor is responsible for full payment. We cannot do third party billing. If this is a divorce or custody situation we will bill the adult accompanying the minor. We no longer bill the non-present adult this is your responsibility.

Missed Appointments:

Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments. There are patients that would be willing to take the appointments at short notice. It is very costly for the doctor and staff to have wasted down time without patients. If more than one appointment is missed we may not reschedule.

I have read the office policy. I understand and agree to this new policy:

X_____ **Date:**_____

Thank you!

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