Brain & Eye Connection Vision Clinic

Carolanne H. Roach, OD 1530 SW 89th St, Bldg D-2, OKC, OK 73159 (405) 703-3163
www.BrainAndEyeConnection.com Fax (405) 353-6718 VisionClinic@BrainAndEyeConnection.com

PRIVACY POLICY, CONSENT TO TREAT AND FINANCIAL RESPONSIBILITY

Patient Name: ____________________________ Birthday: ____________________________

Privacy Policy

I acknowledge that the Notice of Privacy Practices is available at www.brainandeyeconnection.com or the office location where treatment is conducted and that I have read and understood the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided. I also give permission to release protected health information to third party insurances for the purpose of processing insurance claims. I also give permission to send email and text messages for appointment reminders.

Consent to Treat

I authorize Brain & Eye Connection Vision Clinic, PC to treat the patient listed on this form.

Financial Policy

All fees including co-payment, co-insurance, deductibles, and non-covered services (including refraction - $35 charge and possible wellness screening tests - $50) are due and payable on the date of service unless other payment arrangements have been made. I understand that insurance claims are filed as a courtesy and that some testing and/or treatment procedures may not be covered by health insurance, and I will be responsible for those charges. Charges for services will be due upon receipt of a patient billing statement unless specific arrangements have been made for an extension of time. If payments cannot be made when due, please contact our office as soon as the statement is received to arrange a payment plan. Also, a $50.00 fee will be charged for patients that cancel within 48 hours or fail to show up for the scheduled appointment. There is no charge for cancelations made prior to 48 hours before appt.

I have read and understood the above statements and agree to all of the listed items:

____ ____________________
Signature of Patient or Patient's Representative Date

____ ____________________
Printed Name of Patient's Representative Relationship to Patient

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name:________________________ Birthday: _______________ SSN:______________

Please list all doctors, family members, or organizations you wish to have access to your records.

Type of Doctor/Person/Organization	Name of Doctor/Person/Organization	Relationship/Title
☐ Eye Care Physician		MD / DO / OD
☐ Eye Care Physician		MD / DO / OD
☐ Family Doctor(PCP)/Pediatrician		MD / DO
☐ Other Dr. – Neuro/Cardio/Etc.		MD / DO
☐ Occupational Therapist		
☐ Physical Therapist		
☐ Speech Therapist		
☐ Psychologist/Psychiatrist/Counselor		
☐ School/Employer		
☐ Family Member/Friend		
☐ Family Member/Friend		
☐ Family Member/Friend		
☐ Other/hospital		

Specify type of information to be disclosed or requested:

☐ Complete Record ☐ Vision Evaluation Report
☐ Last Comprehensive Exam ☐ Vision Rehab records / Progress notes
☐ Eyeglasses/Contact Lens prescription ☐ Other (specify): ____

This authorization is valid for 12 months after date signed unless specified here: ____________________________
and covers all treatment dates unless specified here: Treatment dates ranging from: ____________ to: ___________

Rights

- I understand that I do not have to sign this Authorization and treatment is not conditioned on obtaining this authorization.
- I have a right to receive a copy of this Authorization.
- I have a right to revoke this authorization at any time by submitting a signed written request. The only exception to this right is if the authorized party has already acted in reliance upon this authorization.
- I understand that if the person(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by the Privacy Rule in the Code of Federal Regulations.
- I understand that a fee may be charged to cover the costs of copying, including the cost of supplies and labor of copying and mailing to anyone other than another health care provider.

By signing below, I authorize Brain & Eye Connection Vision Clinic, PC to obtain or release protected health information as stated above.

____ ______________________
Signature of Patient or Patient's Representative Date

____ ______________________
Printed Name of Patient's Representative Relationship to Patient

Brain & Eye Connection Vision Clinic

Child Medical History Questionnaire

Patient Name: ______________________ **Date of Birth:** __________

Parents Names: **Date of Appt:**

Vision History:

Vision Problems:

Has your child been diagnosed with any of the following? (circle all that apply)

Optic nerve hypoplasia	**Nystagmus**	**Brain injury**	**Retinitis pigmentosa**
Strabismus (eye turn)	**Optic atrophy**	**Brain tumor**	**Rod or cone dystrophy**
Amblyopia (lazy eye)	**Stargardt's**	**Albinism**	**Retinopathy of prematurity**

Other:

List all eye surgeries/injuries: ______________________

Past Eye Care Provider: **Last Visit:**

Medical History:

Pediatrician/Primary Care Provider: **Last Visit:**

List all general surgeries: ______________________

Full term pregnancy? **YES** **NO** If not, how long? ______________

Was oxygen used? **YES** **NO** If so, how long?

School History:

Name of School: Grade:

School Address: Phone:

Does your child have an IEP? **YES** **NO** Accommodations for vision? **YES** **NO**

Describe school difficulties**:** ______________________

Glasses History:

Have glasses been prescribed? **YES** **NO** When were they last Rx'ed:

Does your child wear them? **YES** **NO** Do they help your child? **YES** **NO**

Age your child first got glasses? Have they been changed a lot? **YES** **NO**

When are glasses worn? **full time** **distance only** **near/reading only** **other**

If not worn, why not?

Social:

Setting of Residence: **house** **apartment** **Other:**

Living with: **mother** **father** **foster parents** **adoptive parents** **extended family**

Visual Symptoms:

What activities does your child's vision affect the most? Please list them below:

What type of optical devices or adaptations does your child use at school or home?

Visual Symptoms:

Does your child struggle with any of the following activities or situations?

Bright light or glare	**Yes**	**Some**	**No**	Seeing small objects	**Yes**	**Some**	**No**
Low light or night time	**Yes**	**Some**	**No**	Seeing large objects	**Yes**	**Some**	**No**
Changes in surfaces	**Yes**	**Some**	**No**	Going up/down stairs	**Yes**	**Some**	**No**
Running into things	**Yes**	**Some**	**No**	Central/detail vision	**Yes**	**Some**	**No**
Depth perception	**Yes**	**Some**	**No**	Peripheral/side vision	**Yes**	**Some**	**No**
Detecting dull colors	**Yes**	**Some**	**No**	Keeping track of items	**Yes**	**Some**	**No**
Detecting bright colors	**Yes**	**Some**	**No**	Busy/crowded places	**Yes**	**Some**	**No**

Family Medical History:

Please check all of the conditions that are in your family medical history.

Macular Degeneration	**No one**	**Father**	**Mother**	**Brother**	**Sister**	**Grandparent(s)**
Glaucoma	**No one**	**Father**	**Mother**	**Brother**	**Sister**	**Grandparent(s)**
Retinal Disease	**No one**	**Father**	**Mother**	**Brother**	**Sister**	**Grandparent(s)**
Other Eye Conditions	**No one**	**Father**	**Mother**	**Brother**	**Sister**	**Grandparent(s)**
Diabetes	**No one**	**Father**	**Mother**	**Brother**	**Sister**	**Grandparent(s)**
Heart Disease	**No one**	**Father**	**Mother**	**Brother**	**Sister**	**Grandparent(s)**
High Blood Pressure	**No one**	**Father**	**Mother**	**Brother**	**Sister**	**Grandparent(s)**
Stroke	**No one**	**Father**	**Mother**	**Brother**	**Sister**	**Grandparent(s)**
Alzheimers/Parkinsons	**No one**	**Father**	**Mother**	**Brother**	**Sister**	**Grandparent(s)**
Cancer	**No one**	**Father**	**Mother**	**Brother**	**Sister**	**Grandparent(s)**

Other Family History: ______________________________

Medical History: No Known Medical Conditions ☐

Please circle all the conditions you have or are being treated for or check None.

Constitutional: None ☐

Fatigue	**Significant weight gain**	**Decreased appetite**	**Fever**
Weakness	**Significant weight loss**	**Increased appetite**	**Chills**

Genetic:				None ☐
Septo Optic Dysplasia	Marfan's Syndrome	Down's Syndrome	Bardet Biedl	
Neurological:				**None ☐**
Headaches	Head/brain injury	Cerebral palsy	Concussion	
Migraines	Cognitive impairment	Seizures/ Epilepsy	Narcolepsy	
Ears, Nose, Mouth, Throat:				**None ☐**
Hearing loss	Deafness in right ear	Sinus condition(s)	Vertigo	
Right hearing aid	Deafness in left ear	Seasonal allergies	Tinnitus	
Left hearing aid	Deafness in both ears	Chronic allergies	Nosebleeds	
R&L hearing aids	Usher's Syndrome	Chronic ear infections	Dry mouth	
Cardiovascular:				**None ☐**
High blood pressure	Arrhythmia	Valve disorder	Heart disease	
Respiratory:				**None ☐**
Asthma	Shortness of breath	Pneumonia	Chronic lung disease	
Gastrointestinal:				**None ☐**
Heartburn/reflux	Abdominal pain	Constipation	Liver disease	
Genitourinary:				**None ☐**
Incontinence	Frequent urination	Kidney failure	Dialysis	
Skin:				**None ☐**
Psoriasis	Skin rash	Albinism	Rosacea	
Eczema	Skin bumps/lumps	Dry skin	Itching	
Musculoskeletal:				**None ☐**
Muscular dystrophy	Juvenile rheumatoid arthritis	Scoliosis		
Dyspraxia (poor motor planning)	Low muscle tone	Tortecollis		
Hematologic/Lymphatic:				**None ☐**
Edema/swelling	Anemia	Sickle cell	Blood disorder	Hemophilia
Psychiatric:				**None ☐**
Depression	ADD	Oppositional defiant disorder	Asperger's Syndrome	
Anxiety	ADHD	Obsessive compulsive (OCD)	Extreme irritability	
Bipolar	Autism	Developmental delay	Psychosocial impairment	
Cancer: (Please circle all that apply whether current or past)				**None ☐**
Brain cancer	Neurofibromatosis	Melanoma	Lung cancer	
Retinoblastoma	Non-cancerous tumors	Leukemia	Thyroid cancer	
Neuroblastoma	Basal cell carcinoma	Liver cancer	Lymphoma	
Spinal cord tumor	Squamous cell carcinoma	Kidney cancer	Bone cancer	
Other:				

Endocrine:			None ☐
Hypothyroidism	Pituitary condition	Excessive hunger	Growth hormone disorder
Hyperthyroidism	Adrenal condition	Excessive thirst	Pineal gland dysfunction

Diabetes – Type 1 Type 2	Duration: _________ years
Last fasting blood sugar:	Last HbA1c:

Other conditions not listed above?

Prescriptions/Vitamins/OTC Meds None ☐	mg	AM	Noon	PM	Bed

Eye Drops (Prescription & OTC) None ☐	Which eye(s)?	How often?
	left right both	
	left right both	
	left right both	
	left right both	
	left right both	
	left right both	

Drug Allergies/Reaction to Drug	No known drug allergies ☐
/	/
/	/
/	/
/	/
/	/
/	/