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 ☐
/	/
/	/
/	/
/	/
/	/
/	/

Child Quality of Life Survey

Patient Name: _____ Date: _____

Person Filling out this survey: _____ Relation to Patient: _____

Place a check in the box that corresponds to the frequency of each symptom your child has.

Symptoms	Never 0%	Seldom 1-25%	Occasionally 26-50%	Frequently 51-75%	Always 76-100%
Blur when looking at near	☐	☐	☐	☐	☐
Double vision	☐	☐	☐	☐	☐
Headaches with near work	☐	☐	☐	☐	☐
Words run together when reading	☐	☐	☐	☐	☐
Burning, itchy, watery eyes	☐	☐	☐	☐	☐
Falls asleep when reading	☐	☐	☐	☐	☐
Sees worse at the end of the day	☐	☐	☐	☐	☐
Skips/repeats lines when reading	☐	☐	☐	☐	☐
Dizzy/Nausea with near work	☐	☐	☐	☐	☐
Head tilt/closes one eye when reading	☐	☐	☐	☐	☐
Difficulty copying from far (i.e. chalkboard) to near (i.e. paper)	☐	☐	☐	☐	☐
Avoids near work/reading	☐	☐	☐	☐	☐
Omits small words when reading	☐	☐	☐	☐	☐
Writes up/down hill	☐	☐	☐	☐	☐
Misaligns digits/columns of numbers	☐	☐	☐	☐	☐
Reading comprehension down	☐	☐	☐	☐	☐
Poor/inconsistent in sports	☐	☐	☐	☐	☐
Holds reading material too close	☐	☐	☐	☐	☐
Trouble keeping attention on reading	☐	☐	☐	☐	☐
Difficulty completing assignments on time	☐	☐	☐	☐	☐
Always says "I can't" before trying	☐	☐	☐	☐	☐
Avoids sports/games	☐	☐	☐	☐	☐
Poor eye/hand coordination (i.e. handwriting)	☐	☐	☐	☐	☐
Does not judge distance accurately	☐	☐	☐	☐	☐
Clumsy, knocks things over	☐	☐	☐	☐	☐
Does not use his/her time well	☐	☐	☐	☐	☐
Does not count or make change well	☐	☐	☐	☐	☐
Loses belongings/things	☐	☐	☐	☐	☐
Car/motion sickness	☐	☐	☐	☐	☐
Forgetful/poor memory	☐	☐	☐	☐	☐
Office Use Only **Total** _____	_____	_____	_____	_____	_____

Does your child CURRENTLY experience any of the following?

	Yes	No	If yes, describe:
Eyes frequently reddened	☐	☐	
Frequent eye rubbing	☐	☐	
Frequent sties	☐	☐	
Frowning/Facial distortions when reading	☐	☐	
Bothered by light	☐	☐	
Frequent blinking	☐	☐	
Closing or covering one eye when writing	☐	☐	Which eye?
Difficulty seeing distant objects	☐	☐	
Head close to paper when writing	☐	☐	How close?
Prefers being read to	☐	☐	
Tilts head when reading	☐	☐	Direction of tilt?
Tilts head when writing	☐	☐	Direction of tilt?
Moves head when reading	☐	☐	
Confuses letters or words	☐	☐	
Reverses letters or words	☐	☐	
Confuses right and left	☐	☐	
Vocalizes when reading silently	☐	☐	
Reads slowly	☐	☐	
Uses finger as a marker	☐	☐	
Comprehension decreases over time	☐	☐	
Writes or prints poorly	☐	☐	
Writes neatly but slowly	☐	☐	
Does not support paper when writing	☐	☐	
Awkward or immature pencil grip	☐	☐	
Frequent erasures	☐	☐	
Tires easily	☐	☐	
Eyes hurt	☐	☐	
Eyes tired	☐	☐	
Difficulty recognizing same word on different page	☐	☐	
Poor word attack skills	☐	☐	
Remembers better when hears than sees it	☐	☐	
Responds better orally than by writing	☐	☐	
Seems to know material, but tests poorly	☐	☐	
Poor large motor coordination	☐	☐	
Poor fine motor coordination	☐	☐	
Difficulty with scissors / small hand tools	☐	☐	
Difficulty catching / hitting a ball	☐	☐	

List any other complaints your child makes concerning his/her vision:

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Neuro-Optometric Vision Rehabilitation Policies & Procedures

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

A plan of treatment is prepared for each patient's needs based on thoughtful consideration of the following:

- Visual, medical, and developmental history
- Symptoms of visual difficulty
- Vision examination results
- Desired level of achievement and visual performance

Therapy Sessions

Our provider is recommending a Neuro-Optometric Vision Rehabilitation program to help develop and enhance the visual skills needed for efficient learning and reading. The purpose of vision rehab is to give a foundation for which reading and learning can be built. It is not considered tutoring/educational; it is a medical treatment for medical conditions.

- A therapy session is scheduled for 45 minutes.
- A minimum of 1 session per week is recommended.
  - If other arrangements need to be made, that will be determined by the doctor and/or therapist on an as needed basis.
- The duration of vision rehab varies from child to child. It is impacted by the following variables:
  - The severity of the visual dysfunction
  - The flexibility of the visual system
  - The patient's (and parents') motivation and compliance with the prescribed home activities
- Just like physical therapy or occupational therapy, visual rehabilitation takes time and effort. Patience, compliance, and consistency are needed to develop visual skills properly.

Arrival Time

It is important that you show up on time or slightly early (15 minutes). If you are late for an appointment, our office reserves the right to reschedule you. If the provider does see a late patient, their appointment will be the remaining time of the scheduled visit. This means if you are scheduled at 8:00 am and you show up at 8:30, you will be rescheduled as that would leave 15 minutes of your 45-minute appointment. This would also be considered a missed appointment.

Progress Evaluations/Communications

Our provider assesses the progress of patients every 15 sessions (quarter). At each progress visit, the tests that had below average or borderline normal results will be retested. This could take anywhere from 1 - 3 appointments in addition to regularly scheduled sessions.

Good communication is very important to each patient's success in rehab. If at any time you have questions or concerns regarding the program, please do not hesitate to ask. Our provider wants to make sure that every program is providing benefit to the patient. If you feel that this is not the case with you or your child, please let our office know as soon as possible. This program does take time and is not a quick and easy fix. However, this type of therapy retrains the brain and visual system to work more efficiently and if learned and reinforced correctly will be a long-lasting solution.

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

Attendance/Cancelations/No-Shows Policy

Regular attendance is imperative for the success of our program. It is also respectful to the patients who are waiting to start treatment. We understand that unforeseen circumstances can happen, but consistency is important. Please review our attendance policies:

1. There will be a **$50.00** missed appointment fee for ALL missed sessions without a 24-hour notice.
2. A missed appointment is any regularly scheduled appointment that is moved/canceled/or missed by the patient for illness, conflict of schedule, etc. with or without notification. It is considered missed even when it is made up later.
3. A patient who is ill should NOT come to the office for therapy. If a patient is too sick to go to work/school, he/she is not well enough to get the full benefit from therapy. Sick appointments DO count toward missed appointments.
4. If you need to miss an appointment for any reason, please contact the office at **(405) 703-3163** or text (405) 289-9487 as soon as you know. Our staff can assist in rescheduling a make-up session.
5. If the patient does miss an appointment, the patient will need to schedule a make-up appointment within 2-3 weeks of the canceled appointment at the convenience of the office since open slots are limited. You may do this by calling or texting the office.
6. If two (2) appointments are missed within a quarter (even with 24-hour notice), the patient will receive a verbal warning. All fees will apply to missed appointments and must be paid.
7. If three (3) appointments are missed within a quarter (even with a 24-hour notice), the patient will be placed on probation and receive a written probation letter.
8. If the patient misses 4 appointments within a quarter (even with a 24-hour notice), future appointments will be forfeited, and you will be removed from the program for non-compliance. All fees will apply to missed visits and must be paid.
9. If during therapy, you notice the patient is at a point where they are not retaining training, are burnt out, or is unable to consistently make appointments, please discuss this with the provider. Our office will work through these issues with you. Once patients have been removed from our program for non-compliance, they will be unable to participate in our program in the future.

I have read and understood the Attendance/Cancellations/No-Shows policies. I further understand that it is my responsibility to reschedule any missed appointments within 2-3 weeks.

_____ _____

Patient/Guardian Name: Date

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

Home Activities Policy

Studies have shown that the success of therapy depends highly on how compliant a patient is in doing their home activities. The home procedures prescribed to patients have been designed to allow them to progress through therapy with the most benefit. It is imperative that the prescribed procedures be completed as directed. Our provider feels very strongly about this.

1. If difficulties arise in your home program, please contact our office for suggestions. It is our goal to help patients succeed in every way possible.
2. Home activities are assigned with the understanding that the parents are assisting, observing, and documenting at home. The patient, regardless of age, is NOT to do the therapy on their own.
3. Our online vision therapy program is a required part of therapy unless other arrangements have been made. We require that patients complete all assigned online activities 3 days out of the week and 1 day of binder work each week. Failure to comply with this requirement will result in deactivation of the program with no refund of purchase price.
4. Failure to consistently complete the home activities assigned could result in poor therapy outcomes and termination from the in-office therapy program.
5. If at any time our provider feels that compliance is an issue, the doctor will make recommendations to discontinue therapy.

I have read and understood the Home Activities Policy. I also agree to complete information in the binder concerning home activities, and to communicate any issues with the provider.

_____ _____

Patient/Guardian Name: Date

Costs/Insurance

- All co-pays, co-insurance, deductibles, etc. will be due at each session/progress check/final consult. Please check with your plan to see what these costs will be for you or your child before starting therapy.
- A home activity kit is required for each patient at the beginning of therapy, the cost is: $164.21.
- At progress checks, an additional fee of $50-70.00 will be added when the RightEye oculomotor test is used. This helps us monitor the progress of therapy and is a new technology not covered by insurance.
- If you want additional/special reports throughout therapy, those reports will cost $30-60.00 depending on what is being requested. Initial and final reports are included in the parent consult and final consult visits (though co-pay/co-insurance/deductible may apply).
- If patient discontinuing therapy before the recommended sessions, our online platform will be deactivated and no refund will be issued for online services.

I understand that I have been given an estimation of benefits, and I am responsible for any services not covered by my insurance plan. Those fees will be due at the time of service.

_____ _____

Patient/Guardian Name: Date

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

Observation/Photo/Video Consent Form

In an effort to further the education of optometry students, the public, and others interested in helping their own family members, we occasionally have visitors in our office observing vision rehabilitation sessions. We also occasionally take photos or videos of patients doing vision rehab activities to show others (via our websites, social medic, etc.) about what we do. The goal of all this is to help parents, family members, educators, medical professionals, and others understand our mission to provide children and adults with the necessary visual skills to succeed in school, work, and life.

We would like your permission to allow visitors to occasionally observe _____'s therapy. Please initial by your preference below.

_____ Yes, I give my permission to have _____ observed in vision rehab.

_____ No, I do not wish to have visitors to the clinic observe _____ in vision rehab.

We would like your permission to take photographs or video of _____'s therapy. Please initial by your preference below.

_____ Yes, I give my permission to have _____ photographed or videotaped in vision rehab.

_____ No, I do not wish to have _____ photographed or videotaped in vision rehab.

Vision Rehab Services Policies and Procedures

I have reviewed this Consent Form and have read and understood it.

Signature_____ Date_____

Print Name: _____ Relationship to Patient: _____