Sports Vision Specialists
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ADULT VISION QUESTIONAIRE

For Patients aged 19 years and over

Date of Visit: _____

Patient Name (Last, First, MI) _____ **Preferred Name / Nick Name** _____

Street Address _____ **City** _____ **State** _____ **Zip Code** _____

Home Phone _____ **Cell Phone** _____ **Email** _____

Date of Birth _____ **Age** _____ **Social Security Number** _____

Gender : ☐ **Male** ☐ **Female** **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Other** _____

Do you have Major Medical Insurance? ☐ **Yes** ☐ **No** **Name of Insurance Company: _____**

Name of Policy Holder: _____ **Relationship of Patient to Policy Holder: _____**

Policy Holder Date of Birth : _____

Policy Holder Address: _____

Employer: _____ **Policy Holder SSN: _____**

Please bring cards with you to appointment so they may be scanned into patient file.

If you have more than one policy, please alert office when checking in

Insurance information is requested to be able to complete forms for you to receive reimbursement from your insurance.

Primary Care Physician: _____

Phone Number: _____

HIPPA

I acknowledge that I have had the opportunity to review Dr. Amanda Judson's Notice of Privacy Practices and have been given a copy of the Notice if I requested it.

Patient Signature or Legal Guardian_____Date_____

_____Patient Name _____ Reviewed

SVS *Revised 4/19/2018

Who may we thank for referring you to our office? _____

Why do you feel patient needs a Behavioral Vision Exam/Exam for Vision Therapy?

_____

VISUAL HISTORY

Please answer yes or no to the following Ocular conditions as they apply to the patient

Convergence Insufficiency	☐ **Yes** ☐ **No**	Retinopathy of Prematurity (ROP)	☐ **Yes** ☐ **No**
Tracking Deficiencies	☐ **Yes** ☐ **No**	Ocular Surgery	☐ **Yes** ☐ **No**
Visual Processing Deficiencies	☐ **Yes** ☐ **No**	Loss of Vision	☐ **Yes** ☐ **No**
Visual Focusing Deficiencies	☐ **Yes** ☐ **No**	Retinal Detachment	☐ **Yes** ☐ **No**
Amblyopia (Lazy Eye)	☐ **Yes** ☐ **No**	Ocular Injury	☐ **Yes** ☐ **No**
Strabismus (Turned Eye)	☐ **Yes** ☐ **No**	Chronic Eye Infections	☐ **Yes** ☐ **No**
Previous Vision Therapy	☐ **Yes** ☐ **No**	Stye (Chalazion)	☐ **Yes** ☐ **No**
Eye Patching	☐ **Yes** ☐ **No**	Cataracts	☐ **Yes** ☐ **No**

Please explain any Ocular Conditions marked yes: _____

_____

Do any of the patient's family members (i.e. mother, father, siblings, grandparents) have problems with the above conditions?

(Please list) _____

_____

Date of last Eye Exam: _____ By Whom? _____ Were eyes Dilated? ☐ **Yes** ☐ **No**

Does patient currently wear glasses? ☐ **Yes** ☐ **No** Contact Lenses? ☐ **Yes** ☐ **No**

Do you use a computer? ☐ **Yes** ☐ **No** If yes, How much? _____

If patient has an eye turn, at what age was the eye turn first noticed? _____

Which direction does the eye turn? ☐ Up ☐ Down ☐ In ☐ Out Which eye turns? ☐ Right ☐ Left ☐ Both

Has there been any surgery? ☐ Yes ☐ No If yes, at what age? Which eye? Estimation of Results. _____

_____

Has patching been prescribed? ☐ **Yes** ☐ **No** If yes, please describe at what age patching was started, how it was done, the eye patched, for how long, and estimate of the results. _____

_____

Has vision therapy been prescribed? ☐ **Yes** ☐ **No** If yes, please describe duration of treatment, age at which it was started and estimate the results. _____

_____

HEAD TRAUMA

Has the patient experienced any significant Head Trauma ((Stroke, Head injury, Concussion, Whiplash, Motor Vehicle Accident, Bike Accident, Brain Surgery, etc...)? ☐ **Yes** ☐ **No** Date of Most Recent Event: _____

Describe the injury: _____

_____

_____

_____Patient Name _____ Reviewed

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VISION SYMPTOM SURVEY

EYESIGHT CLARITY

Distance vision blurred and not clear -- even with lenses	☐ Yes	☐ No
Near vision blurred and not clear -- even with lenses	☐ Yes	☐ No
Clarity of vision changes or fluctuates during the day	☐ Yes	☐ No
Poor night vision / can't see well to drive at night	☐ Yes	☐ No

VISUAL COMFORT

Eye discomfort / sore eyes / eyestrain	☐ Yes	☐ No
Headahces or dizziness after using eyes	☐ Yes	☐ No
Eye fatigue / very tired after using eyes all day	☐ Yes	☐ No
Feel "pulling" around eyes	☐ Yes	☐ No

DOUBLING

Double vision	☐ Yes	☐ No
Have to close or cover one eye to see clearly	☐ Yes	☐ No
Print moves in and out of focus when reading	☐ Yes	☐ No

LIGHT SENSITIVITY

Normal indoor lighting is uncomfortable	☐ Yes	☐ No
Outdoor light too bright -- have to use sunglasses	☐ Yes	☐ No
Indoors fluorescent light is bothersome or annoying	☐ Yes	☐ No

DRY EYES

Eyes feel "dry" and sting	☐ Yes	☐ No
"Stare" into space without blinking	☐ Yes	☐ No
Have to rub the eyes a lot	☐ Yes	☐ No

DEPTH PERCEPTION

Clumsiness / misjudge where objects really are	☐ Yes	☐ No
Lack of confidence walking / missing steps / stumbling	☐ Yes	☐ No
Poor handwriting (spacing, size, legibility)	☐ Yes	☐ No

PERIPHERAL VISION

Side vision distorted / objects move or change position	☐ Yes	☐ No
What looks straight ahead -- isn't always straight ahead	☐ Yes	☐ No
Avoid crowds / can't tolerate "visually busy" places	☐ Yes	☐ No

READING

Short attention span / easily distracted when reading	☐ Yes	☐ No
Feel sleepy when reading or doing close work	☐ Yes	☐ No
Difficulty / slowness with reading and writing	☐ Yes	☐ No
Poor reading comprehension / can't remember what was read	☐ Yes	☐ No
Confusion of words	☐ Yes	☐ No
Skip words when reading	☐ Yes	☐ No
Lose place when reading	☐ Yes	☐ No
Have to use finger not to lose place when reading	☐ Yes	☐ No
Words move, jump, swim or appear to float on the page when reading or doing close work	☐ Yes	☐ No
Words blurring or coming in and out of focus when reading or doing close work	☐ Yes	☐ No

_____Patient Name _____ Reviewed

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MEDICAL HISTORY

Does the patient currently or ever have problems with any of these systems?

Gastrointestinal ☐ **Yes** ☐ **No**
(Ulcer, Liver Disease, Gallbladder)
Ear/Nose Throat ☐ **Yes** ☐ **No**
(Hearing problems, Sinus Disease, Tubes)
Endocrine ☐ **Yes** ☐ **No**
(Thyroid Disease, Pituitary Disease)
Diabetes ☐ **Yes** ☐ **No**
(Type 1, Type 2)
Cardiovascular ☐ **Yes** ☐ **No**
(Blood pressure, Heart Disease)
Blood / Lymph ☐ **Yes** ☐ **No**
(Anemia, Bleeding Disorder)
Skin Disorder ☐ **Yes** ☐ **No**
(Rashes, Eczema, Psoriasis)

Nervous System ☐ **Yes** ☐ **No**
(Seizures, Headaches, Multiple Sclerosis)
Genitourinary ☐ **Yes** ☐ **No**
(Kidney Disease, Bladder Disease)
Mental Health ☐ **Yes** ☐ **No**
(Depression, Anxiety, Alzheimer's)
Musculoskeletal ☐ **Yes** ☐ **No**
(Arthritis, Osteoporosis)
Respiratory ☐ **Yes** ☐ **No**
(Asthma, Emphysema, COPD)
Allergic/Immune ☐ **Yes** ☐ **No**
(Autoimmune Disease, HIV, Allergic Status)
Cancer ☐ **Yes** ☐ **No**

Please explain any Health Conditions marked yes: _____
_____
_____

Do any of the patient's family members (i.e. mother, father, siblings, grandparents) have problems with the above conditions? (Please list) _____
_____
_____

Please list any major illnesses, surgeries, or long-term hospitalizations: _____
_____

Is patient currently taking any medications (prescription or non-prescription)? ☐ **Yes** ☐ **No** If yes, Please list: _____
_____

Any Allergies to Medications? ☐ **Yes** ☐ **No** If yes, please list: _____

Any environmental allergies? ☐ **Yes** ☐ **No** If yes, please list: _____

Women only: Are you currently Pregnant? ☐ **Yes** ☐ **No** If yes, how many weeks? _____

Are you currently nursing an infant? ☐ **Yes** ☐ **No**

SOCIAL HISTORY

Occupation: _____ Employer: _____

What are patient's hobbies? _____

Does patient smoke cigarettes / tobacco? ☐ **Yes** ☐ **No** If yes, how often? _____

Does patient drink Alcohol? ☐ **Yes** ☐ **No** If yes, how often? _____

Any other substances? ☐ **Yes** ☐ **No** If yes, explain. _____

**We are required by some insurance plans to ask for this information with the Health History regardless of a patient's age.*

_____Patient Name _____ Reviewed

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REFRACTION SERVICE AND FEE

While there are over 20 different visual skills that compromise vision, an important component of visual care is the refraction. A refraction is the part of the exam by which it is determined whether you can be helped in any way by new glasses or contact lens prescription. It is also how your doctor determines your best possible visual acuity and function of your eye.

It may be necessary to perform a refraction during your Vision Therapy Consultation to assess if spectacle lenses may assist in remediating visual difficulties, even if you have recently had a comprehensive exam with your eye doctor. While there is no charge for a consultation, if a refraction is necessary, you will be responsible for this charge. **The refraction fee is $45.00 and is payable at the time of service.** Dr. Judson will determine during the consultation if this service is necessary and will discuss this potential need with you.

I have read the above information and understand that the refraction is a separate service from the consultation. I accept full financial responsibility for the cost of this service and understand it is due at the time the service is rendered.

_____ _____

Patient Name Patient Signature or Legal Guardian Date

I understand that I am personally responsible for any charges at Sports Vision Specialists.

Patient Signature or Legal Guardian_____Date_____

FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service. We regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Please read and initial each item below that you have read and agree to the following payment terms regarding all services and materials provided by Sports Vision Specialists (SVS).

For patients with Medicaid/HoosierHealthWise/HIP:

_____ 1. I agree to provide a copy of all of my insurance cards and any necessary information to enable SVS to be able to submit insurance claims for my care at SVS.

_____ 2. I authorize the release of any medical information necessary to process all claims.

_____ 3. I understand that I am responsible for payment of my account regardless of insurance coverage or eligibility.

_____ 4. I understand that any check returned to SVS for non-sufficient funds will be subject to a $50.00 fee. I agree to pay this fee in addition to any collection and/or attorney fees incurred in collecting the dishonored check.

_____ 5. I understand that any account balance over 120 days will be turned over to a collection agency or attorney for collection. I will be responsible for all fees incurred in collecting this debt.

_____ 6. I understand that I will be charged a $50.00 non-refundable fee if I fail to notify the office 24 hours in advance when a scheduled appointment must be cancelled or rescheduled.

_____ 7. I understand that if I am insured by Medicaid and have any spend down that has not been met that I will be responsible for that portion. This is not determined until after SVS has filed a claim and received notice from Medicaid. I understand that I will be responsible for any amount shown on the Explanation of Benefits and agree to pay this within 30 days of SVS receiving this notice.

_____ 8. I hereby authorize payment of insurance benefits to be made directly to Sports Vision Specialists for any services or materials provided to me or designated patient as furnished by this supplier. This assignment will remain in effect until revoked by me in writing.

_____ 9. I agree that I will give SVS copies of all of my health insurance cards. I understand that if I am covered by multiple health insurances, that if I receive an Explanation of Benefits (EOB) from my insurance company that I will give SVS a copy of that EOB so that a claim can be submitted to my secondary insurance. I understand that if a check is sent to me for services at SVS, that I am to turn that check over to SVS. I understand that money is not mine and it is insurance fraud to not relinquish that check to SVS. If I refuse to give a copy of all insurance cards and /or copy of EOBs as well as any insurance checks which results in SVS not being able to submit for coverage to its fullest, I understand that I will be financially responsible for all charges.

For patients with Private Insurance/Self-Pay Patients:

_____ 1. I understand that SVS is ***not*** a provider for ANY private vision or private medical plan, and I understand that I am responsible for all fees.

_____ 2. I understand that SVS will ask for a copy of my insurance card to be able to assist me in getting reimbursement from my insurance but that SVS does not file to my insurance company for me nor does SVS accept assignment from my insurance company. I agree to provide a copy of my insurance card and any necessary information to enable SVS to complete insurance forms for me to attempt to submit for reimbursement.

_____ 3. I understand that payment is due at the time of service, unless prior arrangements have been made. I understand the methods of payment accepted by SVS are Cash, Check, VISA, Master Card, Discover, or Debit Card.

_____ 4. I authorize the release of any medical information necessary to process all claims.

_____ 5. I understand that I am responsible for payment of my account regardless of insurance coverage or eligibility.

_____ 6. I understand that any check returned to SVS for non-sufficient funds will be subject to a $50.00 fee. I agree to pay this fee in addition to any collection and/or attorney fees incurred in collecting the dishonored check.

_____ 7. I understand that any account balance over 120 days will be turned over to a collection agency or attorney for collection. I will be responsible for all fees incurred in collecting this debt.

_____ 8. I understand that I will be charged a $50.00 non-refundable fee if I fail to notify the office 24 hours in advance when a scheduled appointment must be cancelled or rescheduled.

I have read, understood and agreed to the financial policy of Sports Vision Specialists.

_____ _____

Patient Name Signature of Responsible Party Date

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HIPPA INFORMATION RELEASE FORM

At Sports Vision Specialists, we take the privacy of your health information seriously. We will not release a patient's health information outside of the allowed exceptions spelled out in our Notice of Privacy Practices without your verbal or written permission.

This form gives you the opportunity to tell us whom we can speak to regarding your health information. You are not required to list anyone and you can change whom we are permitted to speak to at any time by completing a new form.

I authorize Sports Vision Specialists physicians and/or staff to speak to the individuals listed below regarding my health and billing information. I understand that I can revoke this authorization at any time by completing a new form.

_____ _____

Patient Printed Name Date of Birth

Name	Relationship
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

_____ _____

Signature Date

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