Sports Vision Specialists
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INFANT / PRESCHOOLER

For Patients Infant through Pre-K

____
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** ___________

Insurance Information

Do you have Major Medical Insurance? ☐ **Yes** ☐ **No** **Do you have Vision Insurance?** ☐ **Yes** ☐ **No**

Name of Insurance Company: _________________________ **Name of Insurance Company:** ________________________

Policy Holder: _________________________________ **Policy Holder Date of Birth :** ___________________________

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. All co-pays and charges that are the responsibility of the patient are required to be paid on date of service.

Primary Care Physician / Pediatrician: ____

Phone Number: _______________________________________

If Patient is a minor please fill in the following: **Parent/Guardian Marital Status:** ____________________

_______________________________________ ________________________________
Parent / Guardian Name **Relationship to Patient**

_______________________________________ ________________________________
Parent / Guardian Name **Relationship to Patient**

________________________________ Patient Name __________________________ Reviewed

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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

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

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

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

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

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

Has the patient experienced any significant Head Trauma? ☐ **Yes** ☐ **No** If yes, please explain: ________________________________
____

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

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

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. ____
____

Please Check Yes, No, or NA to the following observations and/or complaints as they relate to the patient

	Yes	No	N/A	If yes, when?
An eye turns in or out	☐	☐	☐	____________________________________
Reddened or encrusted eyelids	☐	☐	☐	

______________________________ Patient Name ________________________ Reviewed

VISUAL HISTORY CONTINUED

	Yes	No	N/A	If yes, when?
White appearance in the pupils	☐	☐	☐	____________________
Seems visually unaware	☐	☐	☐	____________________
Has watery eyes	☐	☐	☐	____________________
Turns head to use one eye only	☐	☐	☐	____________________
Tilts head to one side	☐	☐	☐	____________________
Moves objects very close to look at them	☐	☐	☐	____________________
Squints while looking at objects	☐	☐	☐	____________________
Blinks excessively	☐	☐	☐	____________________
Rubs eyes a lot	☐	☐	☐	____________________
Covers or closes one eye	☐	☐	☐	____________________
Stumbles over objects or is clumsy	☐	☐	☐	____________________

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

____

DEVELOPMENTAL HISTORY

Patient is: ☐ **Biological** ☐ **Adopted** ☐ **Foster** ☐ **Other:** ______________________

Length of Pregnancy: ___________ weeks Birth Weight _______________ Mothers Age at Birth ________________________

Did Mother experience any health issues during the pregnancy? ☐ **Yes** ☐ **No** If Yes, Explain:

____

____

Type of Delivery: ☐ Vaginal ☐ Caesarian ☐ Forceps/Vacuum Was Anesthesia used? ☐ **Yes** ☐ **No**

Did patient experience any complications before, during, or immediately following delivery? ☐ **Yes** ☐ **No**

If Yes, Explain: ____

Did patient crawl/creep before walking? ☐ **Yes** ☐ **No** What age did patient start walking? ____________________

Did patient have any developmental delays? ☐ **Yes** ☐ **No** If yes, Explain: ____________________

____

Has patient ever undergone any testing/treatment for the following?

Occupational ☐ **Yes** ☐ **No** Speech/Auditory ☐ **Yes** ☐ **No** Physical ☐ **Yes** ☐ **No**

If any were marked Yes, please explain: ____

____

____

What are your child's hobbies or favorite activities? ____

____

_______________________________ Patient Name _________________________ Reviewed

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MEDICAL HISTORY

Has patient ever been diagnosed with ADD/ADHD? ☐ **Yes** ☐ **No**
If not diagnosed, has someone ever suggested possible ADD/ADHD? ☐ **Yes** ☐ **No** If Yes, who suggested this and why?
____

Has patient ever been diagnosed with Autism? Aspergers,? PDD? PDD-NOS? ☐ **Yes** ☐ **No** If Yes, please explain:
____

Has patient ever been diagnosed with Sensory Integration Issues? ☐ **Yes** ☐ **No** If Yes, please explain:
____

Has patient ever been diagnosed with Auditory Processing Issues? ☐ **Yes** ☐ **No** If Yes, please explain:
____

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: ____

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: ____
____

______________________________ 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 Vision Learning Center, LLC.

Patient Signature or Legal Guardian____Date______________

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

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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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