ROBERT S. FOX, O.D., F.C.O.V.D.

FOX VISION DEVELOPMENT CENTER

1202 Troy-Schenectady Road
Latham, NY 12110
Telephone: (518) 374-8001

Welcome to our office!

Your child will soon be coming for a full developmental vision analysis. This includes testing for vision deficits that can affect overall health, development, self-esteem, coordination, reading, writing, and school performance. To do this we will be assessing his/her eye focusing, eye tracking, eye coordination, acuity, and visual processing skills.

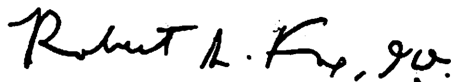
Enclosed you will find our new patient forms that need to be returned to our office **prior to your scheduled appointment**. Please use the enclosed envelope, or fax to our office at 518-374-5923.

The initial evaluation with Dr. Fox is an hour long appointment. This will allow enough time for a comprehensive vision evaluation as well as additional time to address your questions and concerns. The fee for this appointment is $280.00.

If at that time Dr. Fox feels that additional testing is necessary, two additional appointments will need to be scheduled. Your child will complete a 2-hour Visual Processing Evaluation with the Chief therapist while you meet with the Vision Therapy Administrator to learn more about the developmental approach to vision care. After the visual processing evaluation, the second appointment will be scheduled to go over the results from both evaluations and receive your child's program of care recommendation. The fee for these appointments is $380.00 and is due at the time of the visual processing evaluation.

We look forward to meeting you, and helping your child.

Sincerely,



Robert S. Fox, O.D.
Fellow College of Optometric Vision Development

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Welcome. Please fill out this information before arriving at the office.

Child's Full Name ______________________ Age _____ DOB __________
Address (include zip) ______________________
Primary Contact Number: ______________________
Child's School ______________________ Grade ______ Teacher __________
School Address (include zip) ______________________
Who referred you to our office? ______________________

Parent Contact Information:
Parent 1/Guardian Name ______________________
Occupation ______________________ Work Number (_____)__________
Email address ______________________ Cell Number (_____) __________
Marital Status ______________________
Parent 2/Guardian Name ______________________
Occupation ______________________ Work Number (_____)__________
Email address ______________________ Cell Number (_____)__________
Marital Status ______________________

A. Present Situation

1. In what way does your child seem to have visual difficulty? ______________________

2. How does your child complain about his/her vision? ______________________

3. Does your child report any of the following?

	No	Yes	If Yes, When?
Frequent headaches			
Blurred vision when looking far			
Blurred vision when reading			
Double vision			
Eyes "hurt" or "tired			

B. Have you or anyone else noted the following?

	No	Yes	If Yes, When?
Holding reading close			
Cover/Closes one eye			
Frequently loses place when reading			
Eyes frequently reddened			
Frequent styes			
Takes a long time to complete work			
Getting lost in book unaware of surroundings)			
Tilting head when reading			
Reading in bed			
Inability to see distant objects			
Bumping into objects			
Poor general coordination			
Avoids reading/writing			
Bothered by light			

C. School:

1. Age at time of entrance: Kindergarten ________ First Grade ______
2. Does child like school? Yes _______ No ______ Teacher? Yes ______ No _____
3. Has a grade been repeated? Yes _______ No ______ Which ________
4. Have there been any school difficulties? Yes _______ No ______
   If yes, please explain ____
   ____
5. Does child have a 504? _________ Does child have I.E.P.?_________
6. Is school work: Average _____ Better than Average _____ Below Average_____
7. Child's easiest subject ____
8. Child's most difficult subject ____

D. Developmental History:

1. Full term pregnancy _____ Normal Birth _____ Any complications before, during or immediately following delivery? ____
   ____
2. Did your child crawl? YES / NO All fours? _____ Age ______
3. At what age did your child walk? _______
4. Speech (indicate age): First words ________ Sentences ________
   Was speech clear to others? ____
5. Was child active? ____

D. Developmental History (continued):

6. Is your child currently receiving any other services? If yes, how long?
   a. Occupational Therapy ______________________________
   b. Physical Therapy ______________________________
   c. Speech ______________________________
   d. Other ______________________________
7. When fatigued, child does which of the following?
   Sags ______ Becomes irritable ________ Becomes excited _________
   Other: ______________________________
8. When under tension, is there any pattern of behavior, such as thumb sucking, nail biting, etc? ______________________________

   ____
9. List major illnesses, surgeries, and/or current diagnoses:

   ____

   ____
   a. Has your child had frequent ear infections? Yes _______ No ______
10. List Current medications and supplements

    ____

    ____
11. List Allergies

    ____

    ____

E. Visual History

1. How long has difficulties been noticed? ______________________________
2. Previous visual examinations:
   Reason for Examination Doctors Name Date Results

   ____

   ____
3. Members of family who have had visual attention and why:
   Relationship Age Visual Situation

   ____

   ____

   ____

F. Give a brief description of child's personality:

____

____

____

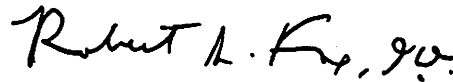
I, _____________________________, give Dr. Robert Fox permission to examine my child's eyes and vision system.

_____________________________________   ____________

Parent/Guardian's signature   Date

Thank you for taking the time to complete this questionnaire. The information you have given will enable us to evaluate the specific visual needs of your child and provide the best possible optometric vision care.

Thank you,



Dr. Robert Fox, O.D., F.C.O.V.D

Primitive Reflex Screening Questions

Were there any medical problems during pregnancy such as threatened miscarriage, high blood pressure, or excessive morning sickness?

YES **NO**

Were there any complications during pregnancy or delivery such as prolonged labor or fetal distress?

YES **NO**

Was a Caesarian section performed?

YES **NO**

Was your child more than 2 weeks premature or 2 weeks late?

YES **NO**

Is there any history of learning difficulties in the family?

YES **NO**

Has your child been diagnosed with a learning disability?

YES **NO**

Has your child been diagnosed with ADD/ADHD or Autism Spectrum Disorder?

YES **NO**

Did/does your child suffer from chronic/frequent ear infections?

YES **NO**

Did/does your child have a history of allergies, asthma, or frequent illness?

YES **NO**

Does your child have a chronic digestive disorder?

YES **NO**

Is/was your child a bed wetter past the age of 5 years old?

YES **NO**

Does your child suffer from motion sickness?

YES **NO**

Has your child ever suffered a head injury?

YES **NO**

Has your child experienced severe emotional stress (i.e. parental divorce, death of someone close, abuse)?

YES **NO**

Was there a lack of, or little, creeping or crawling on all fours with your child?

YES **NO**

Was there any troubles with feeding or latching on in the first 3 months?

YES **NO**

Does your child have difficulty distinguishing between right and left?

YES **NO**

Is, or did, your child have difficulty deciding which hand they would use as their dominant hand?

YES **NO**

Does your child have difficulty sitting still and/or paying attention?

YES **NO**

Does your child have difficulty catching a ball or have poor eye-hand coordination?

YES **NO**

Does/did your child have difficulty learning to ride a bicycle, swim, or swing?

YES **NO**

Does your child become easily anxious?

YES **NO**

Patient Name: ____________________________________

Please fill out this questionnaire.   Thank You.

NAME________________________________DATE____________

Please assign a value between 0 and 4 for each symptom.
4=always / 3=frequently / 2=occasionally / 1=seldom / 0=never or not applicable

1	Blurred vision at (circle) near or distance or both	
2	Double vision	
3	Headaches associated with near work	
4	Words run together or jump around on the page when reading	
5	Skipping or repeating lines when reading (losing your place)	
6	Falling asleep when reading	
7	Vision worse at end of the day	
8	Burning, stinging, watery eyes	
9	Dizziness or nausea associated with near work	
10	Head tilt or closing one eye when reading	
11	Difficulty copying from chalkboard/overhead material	
12	Avoidance of reading and near work	
13	Omitting small words when reading	
14	When reaching for an object you knock it over or your hand misses it	
15	Misaligning digits in columns of numbers	
16	Reading comprehension declining over time	
17	Inconsistent/poor sports performance	
18	Holding reading material too close	
19	Short attention span	
20	Difficulty completing assignments in reasonable time	
21	Avoiding sports and games	
22	Difficulty with writing: inconsistent spacing, writing uphill or downhill	
23	Inability to estimate distance accurately	
24	Car sickness/ motion sickness	
25	Forgetful, poor memory	
26	Difficulty with time management	
27	Difficulty with hand tools-scissors, screwdriver, calculator, keys	
28	Saying "I can't" before trying	
29	Difficulty with money concepts, making change	
30	Misplaces or loses papers, objects, belongings	
	** Total	*

Please have teacher fill out this questionnaire if possible. Thank You.

NAME______________________________DATE____________

Please assign a value between 0 and 4 for each symptom.
4=always / 3=frequently / 2=occasionally / 1=seldom / 0=never or not applicable

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	** Total	*

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Patient Services Contract

Welcome to our practice! Dr. Fox and his staff are looking forward to building a relationship with you or your child to help you best reach your full visual potential. This document contains important information about our offices professional services and business polices. Please read it carefully and write down any question you might have so they can be discussed. When you sign this document, it will represent an agreement between you and our practice.

CANCELLATION POLICY: We typically have a waiting list of patients who are eager to set up appointments as soon as possible. As such, it is important to keep your appointment for the time it was scheduled. This cancellation policy applies to appointments scheduled with the Doctor. Additional information regarding weekly therapy appointments will be provided and discussed at a later date should the need arise.

- Appointments that are cancelled more than 48 hours in advance will *not* be charged a cancellation.
- Appointments that are cancelled the day prior to your appointment will be subject to a $50.00 cancellation fee. These phone calls must be received prior to 5:00pm.
- Appointments that are cancelled the day of your scheduled appointment will be subject to a $75.00 late cancellation fee. This includes calls that are received after 5:00pm on the previous day.
- If you do not show to your scheduled appointment without a prior phone call, a $90.00 fee is charged.

In these cases your credit or debit card will be charge automatically.

BILLING AND PAYMENTS: You are expected to pay for all visits with the Doctor at the conclusion of each visit. Please refer to the credit/debit card payment agreement form for detailed information about how outstanding balances are charged.

Medicare/Workers Compensation/No fault: The office only participates with 3 different insurances, Medicare (government funded, *not* managed care programs), Workers Compensation, and No-Fault. No payment will be collected at the time of services. Medicare patients - you may receive a bill in the mail from Solutions billing on our behalf to collect your insurance companies determined co-pay for our services. Workers Compensation and No-Fault patients please be aware it is important our office receives payment and you will be asked to speak with your attorney in the event that payments are not received.

INSURANCE REIMBURSEMENT: All other patients seen in our office are expected to pay out of pocket for our services. It is important to coordinate with your health insurance company

to find out if they will reimburse for out of network providers for the services we provide. You will be provided an itemized bill after every visit with the Doctor that has all the information needed to complete most paperwork requests from your insurance company. Itemized receipts will only be provided upon request at the conclusion of each therapy session that has been paid in full. It is important to note that we do not accept any payment from insurance companies, including co-pays for our services; it is you as the patient or guardian to be responsible for the full payment of our fees. Please speak with the Patient Care Coordinator or Vision Therapy Administrator if you need additional services and they can help with whatever information they can based on previous experiences.

CONTACTING THE OFFICE: The Doctor and specific staff members are often not immediately available by phone. Please leave a detailed message with the Patient Care Coordinator so that the appropriate member of the staff can return your call as quickly as possible. Often times the Chief Therapist and Certified Therapists in the office are well equipped to answer most questions, and are more readily available to return phone calls than the Doctor.

EMAIL COMMUNICATIONS: Doctor Fox does not correspond with patients via email. If you wish to correspond with the Vision Therapy Administrator or Vision Therapist an email consent form will be provided to you at the appropriate time. Please note, this is not an acceptable way to cancel or reschedule appointments – that can only be done by calling the office.

TEXT MESSAGES: The office does not correspond via text message regarding any of our patients or scheduled appointments.

SOCIAL MEDIA: The office does has a Facebook page and Instagram. We invite you to check in, follow us, like and share our posts! However, we do not use those platforms to contact you regarding your care. Please, do not contact us via these means to ask us questions, and especially to cancel appointments. Any cancelation of appointments via social media will be counted as a no call/no show appointment and you may be held responsible for a cancelation fee per the previously mentioned policies.

STATEMENT OF RELEASE BY SELF/PARENT/GARDIAN TO INSURANCE COMPANY: I authorize Fox Vision Development to release medical information about myself or my child to the applicable insurance company should any information be needed to determined reimbursement of services. By signing this consent, I acknowledge that I have read it or it has been read to me, that I am at least 18 year old, that I understand the above agreement and that I am singing this consent voluntarily.

________________________________ ____________

Patient/Parent/Guardian Signature Date

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Credit Card Authorization Form

Patient Name:____ DOB:_____________

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ❑ MasterCard ❑ VISA ❑ Discover ❑ AMEX ❑ Carecredit ❑ Other __________
Cardholder Name (as shown on card): _________________________________
Card Number: ________________________________ CVC: ____________
Expiration Date (mm/yy): ___________
Cardholder ZIP code (from credit card billing address): _______________________

I, ________________________________, authorize Fox Vision Development to keep my signature on file to charge my credit/debit card listed above for outstanding balances 30 days past due, and late cancelation/no show fees due on the account of the patient named above. The card may be charged **automatically** after the original time and date of service if payment was not provided at the time of service. Receipts will be sent upon payment processing to the address indicated below. I may continue to schedule appointment provided my credit card remains on file, is valid and additional fees are not accrued.

____ __________________

Signature Date

Mail Receipts to:
Name: ____
Street Address: ____
City, State, Zip: ____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY. Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA;

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for heath care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information **without** your authorization:

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

- Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.
- You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.
- We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

- **To request restrictions on the health information we may use and disclose for treatment, payment and health care operations.** We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.
- **To receive confidential communications of health information about you in any manner other than described in our authorization request form.** You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.
- **To inspect or copy your health information.** You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.
- **To amend health information.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:
  - was not created by us, unless the person that created the information is no longer available to make the amendment,
  - is not part of the health information kept by or for us,
  - is not part of the information you would be permitted to inspect or copy, or
  - is accurate and complete.
- **To receive an accounting of disclosures of your health information.** You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).
- **To designate another party to receive your health information.** If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

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I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understood your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name ______________________________

Relationship to Patient ______________________________

Signature ______________________________

Date ______________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this *Notice of Privacy Practices Acknowledgment*, but was unable to do so as documented below:

Date:	Initials:	Reason: