FOX VISION DEVELOPMENT CENTER

ROBERT S. FOX, O.D., F.C.O.V.D.
McKENZIE E. SYMONS, O.D.

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

Welcome to our office!

You will soon be coming for a full eye examination. This includes testing for refractive conditions, eye health, eye coordination, and any other visual concerns based on your history.

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, fax to our office at 518-374-5923, or email to pcc@foxvisiondevelopment.com. If you show up to the appointment without completed forms, we reserve the right to reschedule your appointment.

The office examination permits enough time to complete a thorough Optometric investigation, and should last approximately 45 minutes. This examination will allow Dr. Fox or Dr. Symons to write an eye glass prescription that can be filled at an optical shop of your choosing. The fee for this examination is $225.00.

Please remember the office does not accept any insurance except for Government-funded Medicare or No Fault and we expect payment at the time of your visit.

If you have any questions or concerns that we can answer prior to your appointment, please do not hesitate to contact us by phone (518) 374-8001. You may leave a message for us 24/7 and we will get back to you at our earliest availability.

If you need to cancel this appointment for any reason please contact our office a minimum of 48 hours before your appointment.

We look forward to meeting you.

Sincerely,

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

McKenzie E. Symons, O.D.

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Directions to Fox Vision Development Center

From North:
Take I87 Northway South to Exit 6. Take a right off the exit to get on Route 7 West. Drive 3 miles, then at the light turn left into BSNB Plaza. Veer left and we are in Building 2, on the right.

From South:
Take I87 Northway North to Exit 6. Take a left off the exit to get on Route 7 West. Drive 3 miles, then at the light turn left into BSNB Plaza. Veer left and we are in Building 2, on the right.

From East:
Take Route 7 West. Drive 3 miles past the I87 Northway intersection, then at the light turn right into BSNB Plaza. Veer left and we are in Building 2, on the right.

From West:
Take I90 Thruway East to Exit 25. This puts you onto I890 West. Take I890 West to Exit 7. Go East on Route 7 about 6 miles, then at the light turn right into BSNB Plaza. Veer left and we are in Building 2, on the right.

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Sources for more information on Developmental Optometry and Vision Therapy

Fox Vision Development website – www.FoxVisionDevelopment.com
- Includes information about Dr. Fox and his staff, what is Vision Therapy, Success Stories from our patients and upcoming events in and out of the office.
- Facebook: www.facebook.com/foxvisiondevelopment

College of Optometrists in Vision Development – www.covd.org
- COVD is an international organization that offers certification to Doctors and Vision Therapists as well as educational information for parents and patients.

American Optometric Association – www.aoa.org
- Organization that represents doctors of optometry, Optometry students and paraoptometric assistants and technicians.

Children's Vision – www.children-special-needs.org
- Includes information on Vision Therapy, different visual diagnoses as well as their impact on other diagnoses such as ADD, ADHD, and Autism Spectrum Disorder.

Neuro-Optometric Rehabilitation Association – https://noravisionrehab.org/
- An international group of committed individuals from various disciplines whose focus is on advancing the art and science of rehabilitation for the neurologically-challenged patient.

Optometric Extension Program Foundation – www.oepf.org
- An international organization dedicated to the advancement of the discipline of Optometry through the gathering and dissemination of information on Vision and the Visual process.

College of Syntonic Optometry – https://csovision.org/
- Treatment of the visual system with Phototherapy, for the promotion of human health and potential.

Vision Therapy Facebook Groups
- www.facebook.com/groups/VTparentsunite

NeuroVisual Medicine Institute
- https://nvminstitute.org/

WELCOME TO FOX VISION DEVELOPMENT CENTER

Name_____ Age: _____ Date of Birth: _____
Address: _____ Home Phone: _____
_____ Work Phone: _____
Email: _____ Marital Status: _____
Occupation: _____ Where Employed: _____
Referred by: _____ SS#: _____
Family Physician: _____ Date of Last Exam: _____
Briefly Describe the Reason for Today's Visit: _____
_____

GENERAL HEALTH HISTORY:

Have You Had or Experienced any of the Following: (please check all that apply)

Neurological Disorder	_____	Burning Itchy Eyes	_____
High Blood Pressure	_____	Eye Strain or Fatigue	_____
Diabetes	_____	Double Vision	_____
Thyroid Disease	_____	Blurred Near Vision	_____
Head or Facial Injury	_____	Blurred Far Vision	_____
Frequent Headaches	_____	Light Sensitivity	_____
Allergies (please list)	_____	Spots or Flashes	_____
_____		Water / Dry Eyes	_____
Please list any Medications:		Reading Problems	_____
_____		Eye Injury	_____
Is there a Family History of Glaucoma?		Eye Surgery	_____
_____		Lazy Eye	_____
Have you ever had Vision Therapy?		Sudden Loss of Vision	_____
_____			

LIFESTYLE INFORMATION:

Do you spend time on a computer?	Hours / Day _____
Are you sensitive to light, glare, reflections?	Yes No
Do you want information on thinner, lighter lenses?	Yes No
Have you ever worn contact lenses?	Yes No
Are you interested in contact lenses?	Yes No
Do you participate in sports activities?	Yes No
Do you spend much time outdoors?	Yes No
Do you have prescription sunglasses?	Yes No
Do you have more than one pair of glasses?	Yes No
Do you wear bifocals?	Yes No

WE ACCEPT MEDICARE

If Medicare is your primary insurance, please fill out the following in full

SIGNATURE ON FILE

Medicare ID # : _____ PART : _____
Secondary Ins : _____ ID# _____ Group/Plan_____
Secondary Ins. Address : _____

- o I understand I am responsible for the balance of my bill.
- o I authorize the release of information to my insurance company.

Name of Insured : _____ Relationship : _____
Signature of Insured : _____ Date : _____

PLEASE RETURN TO THE CHECK IN DESK WHEN COMPLETE. THANK YOU.

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	*

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Patient Services Contract

Welcome to our practice! Dr. Fox, Dr. Symons, and the 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/PICK UP 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. A 48 hour cancellation policy applies to appointments scheduled with the Doctors. A pick up policy is applied regarding unaccompanied children. Additional information regarding weekly Vison 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 fee.
- Appointments that are cancelled within 48 hours prior to your appointment will be subject to a $50.00 cancellation fee. These phone calls must be received prior to 5:00 PM.
- If a child is dropped off for an appointment and they are not picked up directly after, a $50.00 fee will be charged for every 15 minutes following a 10 minute grace period.

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

BILLING AND PAYMENTS: You are expected to pay for all visits with the Doctors 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. All patients must have a card on file.

MEDICARE/NO FAULT: The office only participates with 2 different insurances: Medicare (government funded, *not* managed care programs) 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 Medical Billing on our behalf to collect your insurance companies determined co-pay for our services.
- 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. If after 2 appointments we have received no notice of payments, services will be stopped. If services are denied payment, they will be stopped or you can pay out of pocket.

INSURANCE REIMBURSEMENT: All other patients seen in our office are expected to pay out of pocket for our services. 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. It is recommended that you 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 Doctors that has all the information needed to complete most paperwork requests from your insurance company. For Vision Therapy patients, itemized receipts will only be provided upon request at the conclusion of each therapy session that has been paid in full. 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 Doctors 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 Doctors.

EMAIL COMMUNICATIONS: Dr. Fox and Dr. Symons do 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.

SOCIAL MEDIA: The office does have 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/GUARDIAN TO INSURANCE COMPANY: I authorize Fox Vision Development Center 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 signing 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 ❑ Care Credit ❑ 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: