VISION SOURCE®

Advanced Family Eyecare

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14000 Quailbrook Dr., Oklahoma City, OK 73134

(405) 751-7727 Fax (405) 755-1875

Appointment Date: _____ Time: _____

Please fill out this questionnaire carefully, and bring it with you at the time of your child's examination. The office examination will take sufficient time to permit a thorough assessment of your child's visual skills. Your child's future deserves the fullest consideration that you, as parents/guardians, and our office can provide.

GENERAL INFORMATION

Child's full name: _____ Nickname: _____
Present Age: _____ Date of Birth: _____ Gender: ❑ M ❑ F
Race: ❑ White ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic ❑ Native Hawaiian/ other Pacific Island
Ethnicity: ❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑ Native Hawaiian/other Pacific Island
Preferred Language: ❑ English ❑ Spanish
Grade: _____ Teacher: _____ Principal: _____
School Name: _____ City: _____
If referred, who referred you? _____
May we use your name in thanking them? ❑ Y ❑ N
May we leave voicemail messages regarding appointments and care? ❑ Yes ❑ No

PARENT INFORMATION

Father's Name: _____ D. O. B. _____ Social Security Number: _____
Marital Status: Single Married Divorced Legally Separated Widowed
Home Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Employer: _____ Position/Title: _____ Business Phone: _____
Mother's Name: _____ D. O. B. _____ Social Security Number: _____
Marital Status: Single Married Divorced Legally Separated Widowed
Home Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Employer: _____ Position/Title: _____ Business Phone: _____

MEDICAL HISTORY

Is your child generally healthy? ❑ Yes ❑ No
Has your child had any ocular surgery? ❑ Yes ❑ No
If so, please list and date: _____
Most recent medical examination- Doctor's name: _____ Date: _____
Results: _____
Please list any current medical conditions (i.e. asthma, ear infections/tubes, attention deficit disorder, cerebral palsy, etc…):

_____

Current medication(s) and for what condition(s): _____
Medication(s) your child is allergic or sensitive to: _____
Is your child especially afraid of doctors? _____
Does your child or anyone in his/her family have a history of the following: (Please check all that apply)

High blood pressure	❑ Child ❑ Family	Glaucoma	❑ Child ❑ Family
Diabetes	❑ Child ❑ Family	Cataract	❑ Child ❑ Family
Thyroid Condition	❑ Child ❑ Family	Blindness	❑ Child ❑ Family
High Cholesterol	❑ Child ❑ Family	Allergies/Sinus	❑ Child ❑ Family

List illness, bad falls, high fevers, etc. Complications Age

_____ _____ _____

_____ _____ _____

Has a Neurological Evaluation been performed? _____ When: _____

By whom? _____ Results: _____

Any other testing? _____ When: _____

By whom? _____ Results: _____

NUTRITIONAL HISTORY

Is your child on a diet or restricted from particular foods? _____

Does your child ❑ dislike ❑ like ❑ crave sweets? Are there periods of ❑ high-energy ❑ low energy with certain foods?

If so, please explain: _____

DEVELOPMENTAL HISTORY

Was your child adopted? ❑ Yes ❑ No

Full term, normal pregnancy? ❑ Yes ❑ No Were there multiple births with this pregnancy? ❑ Yes ❑ No

Premature? ❑ Yes ❑ No Post-mature? ❑ Yes ❑ No C-Section? ❑ Yes ❑ No Breech Birth? ❑ Yes ❑ No

If premature/post-mature, how much? _____ Length at birth: _____ Weight at birth: _____lbs_____oz Apgar score _____

Any complications before, during or immediately following delivery? _____

Did your child creep (stomach on floor)? ❑ Yes ❑ No Age_____ Crawl (stomach off floor) ❑ Yes ❑ No Age _____

Did your child creep/crawl on all fours? ❑ Yes ❑ No Age_____ If not, describe abnormal creep/crawling: _____

_____

At what age did your child walk? _____ Was your child active? _____ Overly active? _____

Your child's first words were at what age? _____ Was early speech clear to others? _____ Is speech clear now? _____

He/She is ❑ right-handed ❑ left-handed ❑ no preference

EARLY INTERVENTION:

Sooner Start: ❑ Yes ❑ No If yes, which category/categories:

❑ Physical Therapy ❑ Occupational Therapy ❑ Speech Therapy

❑ Developmental Delay ❑ Hearing Impairment ❑ Visual Impairment

VISUAL HISTORY

Reason for seeking developmental visual evaluation: _____

How long have difficulties been noticed? _____

Previous Examinations:

Reason for Examination Doctors Name Date Results

_____

_____

Were glasses prescribed? Yes No Are they worn? Yes No When? _____

List all members of the family that have had visual attention and why:

Name Age Visual Condition Date of visual analysis

Mother _____

Father _____

Brother(s) _____

_____

Sister(s) _____

_____

PRESENT SITUATION

Is there any evidence from the school or a psychological test that some visual malfunction might be present? ❑ Yes ❑ No
If so, what evidence? _____

Does your child report any of the following?

Headaches	❑ Yes ❑ No	When? _____
Blurred Vision	❑ Yes ❑ No	When? _____
Eyes "hurt" or "tired"	❑ Yes ❑ No	When? _____
Print moves, floats or jumps	❑ Yes ❑ No	When? _____

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

SCHOOL

Describe overall school performance: _____
_____
What is your child's attitude toward school, _____ teachers, _____
reading, _____ and other children _____?
Does he/she have difficulty in following oral instructions? _____
What school subjects are best for your child?_____
Specifically describe any school difficulties: _____
_____
School work is: ❑ Below Average ❑ Average ❑ Above Average
Does he/she seem to be under tension or extreme pressure when doing schoolwork? ❑ Yes ❑ No
Age at time of entrance to kindergarten _____ First grade _____
Has he/she changed schools often? ❑ Yes ❑ No When? _____
Has a grade been repeated? ❑ Yes ❑ No If so, what grade and why? _____
Has he/she had any special tutoring and/or remedial assistance? ❑ Yes ❑ No
For how long? _____ Where? _____
In what areas? _____
Results: _____

SPECIAL SERVICES:

❑ 504 Plan ❑ I.E.P. ❑ None - If yes, please provide current paperwork.
If I. E. P., which category/categories:
❑ Physical Therapy ❑ Occupational Therapy ❑ Speech Therapy ❑ Visual Impairment
❑ Developmental Delay ❑ Hearing Impairment ❑ Learning Disabilities ❑ Other Health Impairment

GENERAL BEHAVIOR

Are there any behavior problems? ❑ School ❑ Home
If yes, please describe: _____
What in your opinion causes these problems? _____
Child's reaction to tension ❑ Nail Biting ❑ Thumb Sucking ❑ Other _____
Child's reaction to fatigue ❑ Sluggish ❑ Irritable ❑ Other _____
Does he/she say and/or do things impulsively? ❑ Yes ❑ No Explain _____
Can he/she sit still while watching TV or engaging in their favorite activity? ❑ Yes ❑ No

FAMILY AND HOME

How does he/she get along with parents _____, siblings _____, and friends _____?
Television viewing- How long (time period) _____ How often _____Viewing distance _____
Does your child get so completely involved in television that he/she doesn't hear anything else? ❑ Yes ❑ No
Did father or anyone in father's family have a learning problem? ❑ Yes ❑ No Who? _____
Did mother or anyone in mother's family have a learning problem? ❑ Yes ❑ No Who? _____
Is there any history of mental retardation or psychological disturbance on either side of the family? ❑ Yes ❑ No
If so, who? _____
Do any siblings have a learning problem? ❑ Yes ❑ No Who? _____
To what extent? _____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:

I authorize the release or request of information regarding my child, either verbally or in writing, when necessary for insurance purposes or consultation.

Signed _____ Date _____

Payment is expected at the time services are received. A deposit of 50% is required before materials can be ordered for glasses, contact lenses, or other treatment. A finance charge of 1.5% will be charged on the unpaid balance each month (18% annually). Our office accepts Visa, MasterCard, American Express, and Discover.

You will be provided with a detailed receipt of the visual services you received for insurance purposes. Due to the specialized nature of our testing, we are not participating providers in insurance plans. Insurance benefits therefore, are not accepted as form of payment.

Signed _____ Date _____

Performance Summary

Advanced Family Eyecare

14000 Quailbrook Dr.
OKC, OK 73134
(405) 751-7727
www.afeyecare.com

After you consider each question, mark the column that applies.	**Never**	**Seldom**	**Occasional**	**Frequent**	**Always**
Blur when looking at near	0	1	2	3	4
Double vision, doubled or overlapping words on page	0	1	2	3	4
Headaches while or after doing near vision work	0	1	2	3	4
Words appear to run together when reading	0	1	2	3	4
Burning, itching or watery eyes	0	1	2	3	4
Falls asleep when reading	0	1	2	3	4
Seeing and visual work is worse at the end of the day	0	1	2	3	4
Skips or repeats lines while reading	0	1	2	3	4
Dizziness or nausea when doing near work	0	1	2	3	4
Head tilts or one eye is closed or covered while reading	0	1	2	3	4
Difficulty copying from the chalkboard	0	1	2	3	4
Avoids doing near vision work such as reading	0	1	2	3	4
Omits (drops out) small words while reading	0	1	2	3	4
Writes up or down hill	0	1	2	3	4
Misaligns digits or columns of numbers	0	1	2	3	4
Reading comprehension low, or declines as day wears on	0	1	2	3	4
Poor, inconsistent performance in sports	0	1	2	3	4
Holds books too close, leans too close to computer screen	0	1	2	3	4
Trouble keeping attention centered on reading	0	1	2	3	4
Difficulty completing assignments on time	0	1	2	3	4
First response is "I can't" before trying	0	1	2	3	4
Avoids sports and games	0	1	2	3	4
Poor hand/eye coordination, such as poor handwriting	0	1	2	3	4
Does not judge distances accurately	0	1	2	3	4
Clumsy, accident prone, knocks things over	0	1	2	3	4
Does not use or plan his/her time well	0	1	2	3	4
Does not count or make change well	0	1	2	3	4
Loses belongings and things	0	1	2	3	4
Car or motion sickness	0	1	2	3	4
Forgetful, poor memory	0	1	2	3	4

Normal Score…..0-19
Suspect Problems….. 20-24
Examination Needed…..25 or Greater

NOTICE OF PRIVACY PRACTICES

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Oklahoma City, OK 73134
Office (405) 751-7727
Fax (405) 755-1875
Web: www.afeyecare.com

THIS NOTICE DESCRIBED HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
(Revised 7-2013)

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care issues. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses; contact lenses; or eye medication and sending 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. Example of how we use or disclose your health information for payment purposes are: asking you about you health or vision care plan, or other source of payment; preparing and sending bills or claims; and collecting unpaid balances (either ourselves or through a collection agency or attorney). "Health care operations' mean those administrative and managerial functions that we have to do 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.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, (we will) (we usually will not) ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, that law allows or requires us to use or disclose your health information without your permission. 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 of 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 notice to and from the Federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect, of domestic violence,
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audit by Medicare or Medicaid; for investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceeding, 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 or 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 purpose; or for the evaluation and health of members of the foreign service;
- Disclosure of de-identified information; unidentified
- Disclosure 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" who perform health care operations for us and who commit to respect the privacy of your health information;
- Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/ or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DICLOSURES

We will not make any other uses or disclosures of you health information unless you sign a written "authorization form". The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person at the beginning of this notice.

We will not use or disclose any protected health information for marketing purposes or disclosures that constitute a sale of protected health information without your consent. Additionally, any other uses and disclosures not described in this notice will be made only with your authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purpose of treatment (except emergency treatment), and payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal E-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this notice.
- Ask to see or to get photocopies of your health information. By law, these are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of

your health information within 30 days of asking us (or sixty days if the information is stored off- site). You may have to pay for photocopies in advance. If we deny your request we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have a 30 day extension of time for us to give you access or photocopies of your health information. Send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this Notice.

- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree we will amend the information within 60 days of your request. We will send the corrected information to persons we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position that we will include with your health information along with any rebuttal statement. We will send this with your health information whenever a permitted disclosure is requested/ needed. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. IF you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax, or E-mail shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want).By law, the list will not include: disclosure for purposes of treatment payment or health care operations; disclosures for authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it. By law we can have a 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E- mail shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. Does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax, or E-mail shown at the beginning of the Notice.
- You may restrict certain disclosures of protected health information to a health plan when you pay out of pocket in full for the health care item or service.
- In the event that there is a breach of unsecured protected health information, you will be notified by our office within 30 days of the breach.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that may generate in the future. If we change our Notice of Privacy Practice, we will post the new notice in our office, have copies available in our office, and post it on our Website.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or 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 at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Advanced Family Eye Care Your *Vision Source!* Notice of Privacy Practices.

Patient Name: _____

Signature:_____

Date: _____

Authorization for Release of Information

I hereby request the disclosure of information from my record.

Patient Name: _____
Address: _____
City/State/Zip:_____/_____/_____
Phone: (_____)_____ DOB: _____/_____/_____

The information is to be released **TO/FROM**:

Name/Agency: _____
Address: _____
City/State/Zip:_____/_____/_____
Phone: (_____)_____
Fax: (_____)_____
E-mail: _____
Contact Person(s): _____

The information is to be released by mail, phone, email, or fax **TO/FROM**:

Advanced Family Eyecare
14000 Quailbrook Dr.
Oklahoma City, OK 73134
(405) 751-7727/ fax (405) 755-1875

The information to be released is as follows:

❑ Any information contained in the patient's record

❑ Only information related to the patient's educational success (Specify)

_____
_____
_____

- I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date authorized.
- I understand that the recipient of the disclosed protected health information may not have any legal obligation to maintain the further confidentiality of the protected health information.
- We cannot refuse to treat you if you choose not to sign this form.

Signature: _____ Date: _____
(Patient, Parent, or Legal Guardian)