Heartland Eye Consultants
Pediatric Patient Demographics

Last Name: _____ First Name: _____M.I. _____

Street Address: _____ Apt #_____ Gender: ○M ○F Date of Birth: _____/_____/_____

City: _____ State: _____ Zip Code: _____ Home: (_____) _____ Soc. Sec. No. _____-_____-_____

Primary Language: ○English ○Spanish ○French ○Other_____ ○I decline.

Race: ○American Indian or Alaska Native ○Asian ○African-American ○Pacific Islander ○White ○Other Race ○I decline

Ethnicity: ○Not Hispanic or Latino ○Hispanic or Latino ○Other _____ ○I decline.

Special Needs: ○Hearing Impaired ○Wheelchair ○Translator ○None ○Other_____

Which doctor referred you to our office? _____ If not, please list _____

Who performed your last eye exam? _____ Date: ____/____/_____

Pediatrician/Family Physician: _____

Emergency Contact: _____ Relationship: _____ Phone: _____
(Not living in household) (Area Code)

Please place an X in the boxes to indicate with whom the child lives:

☐**Father's Last Name**:_____**First Name**:_____ M.I.____ Birthdate: _____/_____/_____

Address _____ City:_____ State:_____ Zip Code:_____

Cell Phone: (_____)_____ Home Phone:(_____)_____ Work Phone(_____)_____

Please provide your EMAIL address for appointment purposes only:_____

SSN:_____ Employer: _____Occupation_____Title: _____

Employer's Address:_____ City_____State_____Zip_____ Work Phone_____

☐**Mother's Last Name**:_____**First Name**:_____ M.I.____ Birthdate: _____/_____/_____

Address _____ City:_____ State:_____ Zip Code:_____

Cell Phone: (_____)_____ Home Phone:(_____)_____ Work Phone(_____)_____

Please provide your EMAIL address for appointment purposes only:_____

SSN:_____ Employer: _____ Occupation_____Title: _____

Employer's Address:_____ City_____State_____Zip_____ Work Phone_____

☐Step-Parent's Last Name: _____ First Name:_____M.I.____ Birthdate: _____/_____/_____

The person requesting services for a minor is the responsible party.

We will file major medical insurance coverage for you if you provide us with a copy of your current card. For patients without insurance coverage, you will be responsible for payment today by cash, check or credit card. (**We accept MasterCard or Visa**.)

Photo Release: I hereby grant Heartland Eye Consultants, L.L.C. and Developmental Vision Associates, P.C. permission to have my child's photograph taken for patient information. This does not allow them to use my child's likeness in photographs and/or video in any of its publications or media.

AUTHORIZATION TO RELEASE INFORMATION TO YOUR INSURANCE COMPANY AND
ACKNOWLEDGEMENT OF PERSONAL RESPONSIBILITY FOR PAYMENT

I hereby assign all medical benefits (to which my child is entitled) to the doctor caring for my child. This includes major medical benefits, Medicare, Medicaid, private insurance and any health plans in which I am enrolled. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by my insurance and that 15% APR will be applied to all accounts not paid within 30 days. I hereby authorize the holder of my medical and patient registration records to release any information need to process my insurance claims. I understand that I am the guarantor of this account.

$15 Fee may incur if a copy of my medical records are requested in writing and will be provided whomever I designate.
$25 Fee will incur for all returned checks.
$50 A deposit will be required to schedule an appointment if you fail to keep an appointment or if you repeatedly reschedule your appointment with less than a 48 hour notice. This deposit will be credited to your bill if you keep your appointment as scheduled. However, you will forfeit the deposit if you No Show or reschedule again with less than a 48 hour notice.

Authorized Signature: _____ **Date of Signature**: _____

PLEASE INITIAL _____ **You have read and are aware of the HIPAA privacy policy and agree with its provisions.**

CHILDREN'S VISION HISTORY

When completing this for a minor child, please be sure to answer the questions with regard to him/her.
Be careful to *fill in every blank*. This will help your doctor better understand your child.
Please email or fax this form to us or bring it with you to your appointment. Thank you!

First Appointment: _____
Day **Date** **Time**

CHILD'S FULL NAME_____DOB____/____/_____AGE ____ ___

☐ Male ☐ Female Grade_____ Reading Level _____ Years Months

PARENT'S FULL NAMES:

Mother_____Father_____

Step-Mother_____Step-father_____

VISUAL HISTORY:

Age at *first* eye exam? _____years
Doctor's name:_____ City/State:_____
Were glasses prescribed? ☐Yes ☐ No Were the glasses actually worn? ☐ Yes ☐ No

Was vision therapy recommended? ☐ Yes ☐ No
Has your child ever had vision therapy? ☐ Yes ☐ No

PRESENT VISION CONDITION:

Why do you believe your child needs a vision evaluation?_____
_____
How long has this problem/difficulty been present?_____

Does your child report any of the following?

	YES	NO	If yes, when?
Itching/Burning/Redness	☐	☐	_____
Eyes tired/hurt	☐	☐	_____
Blurry vision	☐	☐	_____
Double vision (1 object seen as 2)	☐	☐	_____
Words move around on the page	☐	☐	_____
Motion/car sickness	☐	☐	_____
Headaches	☐	☐	_____

Have you or anyone else ever noticed the following behaviors in your child?

	YES	NO	If yes, when?
Eyes frequently reddened	☐	☐	_____
Frequent eye rubbing	☐	☐	_____
Frowning	☐	☐	_____
Frequent blinking	☐	☐	_____
Closing or covering one eye	☐	☐	_____

Head close to paper when reading/writing	☐	☐	_____
Avoids reading	☐	☐	_____
Prefers to be read to	☐	☐	_____
Tilts head when reading or writing	☐	☐	_____
Moves head when reading	☐	☐	_____
Confuses letters or words	☐	☐	_____
Reverses letters or words	☐	☐	_____
Confuses right and left	☐	☐	_____
Skips, rereads or omits words	☐	☐	_____
Loses place while reading	☐	☐	_____

	YES	NO	If yes, when?
Vocalizes when reading silently	☐	☐	_____
Reads slowly	☐	☐	_____
Uses finger as a marker	☐	☐	_____
Poor reading comprehension	☐	☐	_____
Needs to re-read to understand	☐	☐	_____
Comprehension decreases over time	☐	☐	_____
Writes or prints poorly	☐	☐	_____
Writes neatly but slowly	☐	☐	_____
Frequent erasures	☐	☐	_____
Tires easily	☐	☐	_____
Difficulty copying from chalkboard	☐	☐	_____
Poor word attack skills	☐	☐	_____
Difficulty with memory	☐	☐	_____
Remembers better by listening than reading	☐	☐	_____
Oral responses better than written responses	☐	☐	_____
Knows material but does poorly on tests	☐	☐	_____
Dislikes/avoids near tasks	☐	☐	_____
Short attention span/loses interest	☐	☐	_____
Clumsy & uncoordinated	☐	☐	_____
Dislikes/avoids sports	☐	☐	_____
Difficulty catching/hitting a ball	☐	☐	_____
Difficulty riding a bicycle	☐	☐	_____

DEVELOPMENTAL HISTORY

Were there any complications with pregnancy or at birth? ☐ Yes ☐ No
Was there ever any concern over your child's general growth or development? ☐ Yes ☐ No _
Was there any use of alcohol, drugs, medication, or cigarettes during the pregnancy? ☐ Yes ☐ No
Pediatrician's Name: _______Date of last examination:_____

EDUCATIONAL HISTORY

☐ Yes ☐ No Do you think your child is working up to his/her potential in school?
☐ Yes ☐ No Does it take him/her several hours to do 20 minutes worth of homework?
☐ Yes ☐ No Can s/he read a paragraph once and comprehend what s/he has read?
☐ Yes ☐ No Does s/he choose reading as a leisure activity?
☐ Yes ☐ No Are spelling words from last year's spelling list spelled correctly in creative writing this year?
☐ Yes ☐ No Does it take more effort for him/her to get the grades than you think it should?

Does your child like school? ☐ Yes ☐ No

Specifically describe any school difficulties:_____
_____
_____
_____
_____

Has your child changed schools often? ☐ Yes ☐ No If yes, during which grade(s)_____
Does your child seem to be under tension or extreme pressure when doing school work? ☐ Yes ☐ No
Has your child had any special tutoring, educational therapy or remedial assistance? ☐ Yes ☐ No
Overall, school work, compared to classmates is: ☐ above average ☐ average ☐ below average
Which subjects are: Above average:_____
Average_____
Below average: _____
To what extent do you assist your child with homework? _____
Does the teacher believe your child is achieving up to his/her potential? _____

Has your child had any evaluations (psychological, special educational, etc.) at school?
☐ Yes ☐ No
If yes, please have the school forward copies of the results, especially cognitive (IQ) tests.
Are there any behavior problems at school? ☐ Yes ☐ No If yes, what? _____
_____
_____
Are there any behavior problems with homework (Homework Wars?) ☐ Yes ☐ No If yes, what?
_____
_____
_____

Child's reaction to fatigue? ☐ irritable ☐ wilts or sags ☐ other _____

Does your child say and/or do things impulsively? ☐ Yes ☐ No

FAMILY AND HOME

Please indicate which adult(s) s/he lives with? ☐Mother ☐Father ☐Step-Mother ☐Step-Father ☐Adoptive Parents ☐Foster Parents ☐ Grandmother ☐Grandfather ☐Aunt ☐Uncle ☐Other Caretaker (please specify)_____

Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, evere parental or sibling illness)? ☐ Yes ☐ No If no, skip this section. If yes, at what age? _____
Does your child seem to have adjusted? ☐ Yes ☐ No
Was counseling/therapy undertaken? ☐ Yes ☐ No If yes, is it on-going? ☐ Yes ☐ No
Is family life stable at this time? ☐ Yes ☐ No If no, please explain:
_____
_____

How does your child get along with: Parents:_____ Siblings:_____ Peers: _____
Did bio-father or anyone in bio-father's family have a learning/reading/spelling problem?
☐ Yes ☐ No If yes, who?_____
Did bio-mother or anyone in bio-mother's family have a learning/reading/spelling problem? ☐ Yes ☐ No If yes, who?_____

Do any (or did any) of the other children in the family have learning/reading/spelling problems? ☐ Yes ☐ No
If yes, who?_____ _

How much does your family read for pleasure? _____

TELEVISION VIEWING/LEISURE TIME ACTIVITIES

Do you have cable TV? ☐ Yes ☐ No How many hours of TV does your child watch per day?_____
At what viewing distance? _____
Do you have DSL or cable internet connection in your home? ☐ Yes ☐ No
How much time does your child spend time using a computer or video games? _____ hrs/day
What other activities occupy your child's leisure time?_____
_____

Please give a brief description of your child as a person:

_____
_____
_____
_____

Is there any other information you believe would be helpful/important in our treatment of your child?

_____
_____
_____
_____

Who helped in the completion of this form? (relationship to patient)_____

_____ _____
Signature Date of Completion

HEARTLAND EYE CONSULTANTS

9900 Nicholas Street ○ Suite 250 ○ Omaha, NE 68114
402-493-6500 ○ Fax: 402-493-4370

TEACHER'S OBSERVATIONS

(Please complete in ink)

Student's Name:________

Grade _____ School _____

The child named above is receiving a Visual Evaluation at our office. In order to more clearly assess the impact of vision problems on classroom performance, we request your observations of this child.

Please respond to the items pertinent to this child and return the report to us as soon as possible. Your cooperation will be greatly appreciated.

If multiple teachers respond, please use different colored pens *on the same form*.

Please do not duplicate the form. Thank you.

Sincerely,

The Doctors at Heartland Eye Consultants

OBSERVABLE CLASSROOM BEHAVIORS POSSIBLY RELATED TO VISION PROBLEMS

APPEARANCE OF THIS STUDENT'S EYES

_____ One eye turns in or out (at any time)
_____ Reddened eyes or lids
_____ Eyes tear excessively
_____ Encrusted eyelids
_____ Frequent sties on lids

THIS STUDENT COMPLAINS TO YOU ABOUT:

_____ Headaches in forehead or temples
_____ Burning or itching after reading or desk work
_____ Nausea or dizziness
_____ Print blurs after reading a short time
_____ Print "runs together" or jumps
_____ Blurred when looks up from reading
_____ Other Explain_____

BEHAVIORAL SIGNS OF VISUAL PROBLEMS

EYE MOVEMENT ABILITIES (Ocular Motility)

_____ Head turns when reading across the page
_____ Loses place often while reading
_____ Needs finger or marker to keep place
_____ Displays short attention span in reading or copying
_____ Frequently omits words
_____ Writes up or down hill on paper
_____ Rereads or skips lines unknowingly
_____ Orients drawings poorly on page

EYE TEAMING ABILITIES (Binocularity)

_____ Complains s/he sees double
_____ Omits letters, numbers or phrases when reading
_____ Misaligns digits in number columns
_____ Reverts to "drawing with fingers" to determine similarities and differences
_____ Squints, closes or covers one eye
_____ Tilts head (extremely) while working at desk
_____ Consistently shows gross postural deviations at <u>all</u> desk activities

VISUAL MOTOR INTEGRATION

_____ Must use kinesthetic input to assist in interpretation
_____ Eyes not used to "steer" hand movements (extreme lack of orientation, placement of words or drawings on page)
_____ Writes crookedly, cannot stay on ruled lines
_____ Irregular spacing of letters within a word
_____ Irregular spacing of words
_____ Poor pencil grip
_____ Uses other hand as "spacer" to control spacing and alignment on page
_____ Misaligns both horizontal and vertical series of numbers
_____ Uses his hand or finger to keep his place on the page
_____ Repeatedly confuses left-right directions

VISUAL PERCEPTUAL SKILLS (Non-motor)

_____ Mistakes words with same or similar beginnings
_____ Confuses similar endings of words
_____ Does not know the same word in the same or next sentence
_____ Confuses likenesses and minor differences
_____ Reverses letters and/or words in writing and copying
_____ Fails to visualize what is read either silently or orally
_____ Whispers to self for reinforcement while reading silently

REFRACTIVE STATUS

(Nearsightedness, Farsightedness, Focusing Problems)

_____ Comprehension reduces as reading continues; loses interest too quickly
_____ Mispronounces similar words as reading continues
_____ Blinks excessively at desk tasks and/or reading only
_____ Fatigues easily (blinks a lot after desk tasks)
_____ Holds book too closely to face or is too close to desk surface
_____ Avoids desk work
_____ Complains of discomfort in tasks that demand visual interpretation
_____ Closes or covers one eye when reading or doing desk work
_____ Makes errors in copying from chalkboard (or reference book) to paper
_____ Squints to see chalkboard, or requests to move nearer to chalkboard
_____ Rubs eyes during or after short periods of visual activity

CLASSROOM BEHAVIOR

Please mark ✓for all appropriate items

_____ Withdrawn, aggressive, other (list) _____ (Circle)
_____ Behavioral problem(s) list _____
_____ Difficulty sitting still
_____ Difficulty maintaining interest in task at hand
_____ Difficulty making friends

PLEASE COMMENT ON THE FOLLOWING QUESTIONS:
What is your major concern for this child academically?

Is s/he in the top, middle, or lower third of her/his class? (Circle)
Deficit in **reading** on standardized tests? Yes No Not yet tested (Circle) Year of test _____
Deficit in **math** on standardized tests? Yes No Not yet tested (Circle) Year of test _____
What <u>grade level equivalent</u> is this child's Independent Reading Level? (Adequate comprehension and recall with no help) _____ (Please do not skip this important question.)
Is this child an average or above average speller? Yes No (circle one)
Once passed on spelling test, are most words retained and correctly spelled on subsequent creative writing projects? Yes No (circle one)
If *No*, does this child spell phonetically during creative writing assignments? YES NO (Circle)

Please check any other special areas of difficulty.

_____ Vocabulary	_____ Memory	_____ Word recognition
_____ Reading *Rate*	_____ Comprehension	_____ Interpretation
_____ Attention	_____ Oral Reading (fluency)	_____ Silent Reading

If s/he is reading below grade level, what do you believe are/were the major factors interfering with learning to read?

When the child was being taught to read in first and second grades, what percentage of the time was phonics used? _____% whole language system? _____%

What method of reading does this child utilize most of the time? Phonics Whole word

Has WISC-IV been given? *(Please circle)* YES NO

If yes, please have the school psychologist send the results as soon as possible.

Any other observations or comments?

If this child enters Optometric Therapy, we will want to communicate with you about his/her progress. We know that you are busy and that your time is valuable. Email tends to be the most effective form of communication. If you are restricted from releasing your email address, how you would like us to communicate with you? Please provide phone number, best day of the week, and best time of day.

Classroom Teacher (print name) _____
Signature _____ Date_____
Email Address: _____
Alternate Contact Information: _____

Resource Teacher (print name) _____
Signature _____ Date_____
Email Address: _____
Alternate Contact Information: _____

SpEd Teacher (print name) _____
Signature _____ Date_____
Email Address: _____
Alternate Contact Information: _____

Thank you very much for your valued input

HEARTLAND EYE CONSULTANTS

9900 Nicholas Street ○ Suite 250 ○ Omaha, NE 68114
402-493-6500 ○ Fax: 402-493-4370

Codes for Pre-Approval

Thank you for choosing Heartland Eye Consultants! As you may already know, your insurance may require pre-approval from your primary care physician for each of the visits to Heartland Eye Consultants. As a convenience to you, below are the codes that may be needed for pre-approval for you/your child's visits at Heartland Eye Consultants (Tax ID # 34-2048045):

New Patient Examination (Insurance Code): 99204
Refraction (CPT Code): 92015

Eye Teaming Examination (Insurance Code): 99214
Electro-diagnostic Eye Movement Test (Insurance Code): 92499

Visual Perceptual Testing 4 units (Insurance Code): 96116 & 96121
Parent Consultation (Insurance Code): 99358
Progress Examinations (Insurance Code): 99214
(These will be administered every 6-8 weeks after therapy begins)
Post-Therapy Re-Evaluations (Insurance Code): 99213

Optometric Neurorehabilitative Therapy, if prescribed will be provided through our sister company Developmental Vision Associates, P.C. (DVA). ***DVA is a separate company that is a non- participating provider with all insurance companies.*** This means that all fees will be paid by the patient and any reimbursement from the insurance company will be paid directly to the patient.

The code for therapy for Developmental Vision Associates (Tax ID# 20-8120553) is 92065 & 92499.

If you have any questions please don't hesitate to call our office at (402)-493-6500.

EXPLANATION OF FEES

Dear Parents:

Headaches, poor academic performance, ADD/ADHD and eye strain are often caused by undiagnosed and untreated visual problems 15% of the time. You may have already come to the conclusion that glasses and educational intervention are not the answer to your child's problems. We have over 45 years combined experience in visually-related learning disorders at Heartland Eye Consultants. It is important to understand that the kind of vision care the doctors provide goes beyond routine eye care. Their neuro-developmental examination of a child is best thought of as a step-by-step process that methodically collects pieces of a puzzle that are then assembled to reveal the *whole visual function* of the child. This letter describes the examinations needed to thoroughly evaluate all systems that can contribute to these often frustrating problems.

There are three levels of vision examination that need to be completed. The first level is a thorough examination of the eyes (with dilation). It is performed to determine the best possible prescription, if needed, and to rule-out any eye disease. This exam is *covered* by *most* major medical insurance policies. We do not participate in "vision/eyeglass" plans; therefore you may be responsible for a portion of your examination. Insurance codes that are typically used are: 99204 and 92015.

The second level of vision testing is done to determine if eye-teaming abnormalities exist that may be disturbing your child during reading or writing activities in school or at home. These issues can cause loss of place, poor comprehension or recall while reading, double vision, blur, headaches, etc. *Most* of this exam is covered by *most* major medical insurance policies. The insurance codes used are: 99214 and 92499.

The third level of vision that is examined tests your child's ability to process and utilize their vision. If your child has no academic issues and is reading at or above grade level these tests may not be recommended. This evaluation utilizes standardized, objective developmental visual perceptual tests with analysis of the results and consultation with the doctor. The testing is done in two sessions and includes assessments of vision that is not covered in any other type of evaluation done by school psychologists, teachers or your primary eye doctor. We are not testing visual acuity, knowledge or IQ, but rather your child's ability to use vision to learn. These tests are covered by some insurance companies and not by others. The insurance codes used are 96116, 96121 and 99358. Some insurance companies have reclassified mild developmental delays as non-medical and therefore deny payment for testing or treatment. It is not an indication of the tests' worth or significance to your child. It is simply a choice the insurance company made to lower your monthly premiums.

We look forward to helping you find the answers to your questions about your child's vision problems. Helping children attain trouble-free reading and learning is one of our passions at Heartland Eye Consultants!

Sincerely,

Patient Care Services