Neuro Eye Team Exams Attendance Agreement

In order to uphold efficiency and best serve our patients during appointments, we have created the following attendance policies. Please review the policies below and sign. We appreciate your understanding and willingness to help us help you!

1. Cancellations-
   a. All cancellations for appointments made within 48 hours of your appointment will result in a $50.00 cancellation fee, unless the cancellation is due to an extenuating circumstance that has been approved by management. Patients will be required to pay this cancellation fee prior to rescheduling their canceled appointment. Failure to pay cancellation fees can result in outstanding balances being sent to collections, so please be sure to pay fees in a timely manner.
2. No show-
   a. Failure to attend your appointment without prior notice will result in the appointment being marked as a No Show. There is a $50.00 fee for No Show appointments. Patients will be required to pay this fee prior to rescheduling their appointment. Failure to pay fees can result in outstanding balances being sent to collections, so please be sure to pay fees in a timely manner.
   b. Reoccurring No Show appointments can result in dismissal of patient care and referral to another practice for continuation of care if needed.
3. Rescheduling Appointments-
   a. Our office will reschedule an appointment up to 2 times. A need to reschedule an appointment after 2 rescheduled appointments will need to be approved by management to be rescheduled.
4. Tardiness-
   a. If a patient arrives more than 10 MINUTES LATE for their appointment, we will need to reschedule your appointment to ensure that we will have enough time to thoroughly assess you.
5. Patient Paperwork-
   a. Please complete patient paperwork through our online portal prior to your appointment. If you are unable to complete this paperwork online, you must ARRIVE 30 MINUTES before your appointment to complete paperwork in our office.

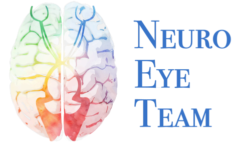
Your signature below states that you understand our attendance policies and will abide by them accordingly.

Patient Name_____________________________________

Patient/Guardian Signature________________________________

Thank you for your cooperation! We look forward to working together!

-Neuro Eye Team



PATIENT INFORMATION FORM

How did you hear about us? ____________________

Patient's Name: ____________________

Nickname:____________________Date of birth:____________________Gender: ☐ Male ☐ Female

Address:____________________

Phone number:____________________Email:____________________

Parent/Guardian Name(s): ____________________

Relationship to Patient: ____________________

Patient's school:____________________

Patient's grade: ____________________

Hobbies:____________________

Names and ages of immediate family: ____________________

Primary reason for today's visit: ____________________

OCULAR HISTORY

Date of last eye exam: ____________________ Previous doctor/clinic: ____________________

Do you have glasses? ☐ Yes ☐ No If yes, when are they used? ☐ Distance ☐ Near ☐ Both

Do you have contacts? ☐ Yes ☐ No If yes, what brand (if known)?:____________________

Do you ***currently*** have any **eye diseases**?

☐ Cataracts ☐ Glaucoma ☐ Styes ☐ Keratoconus ☐ Macular degeneration

☐ Other (explain):____________________

List any eye injuries/surgeries: ____________________

List any eye drops used and frequency: ____________________

CURRENT MEDICAL INFO: CHECK Yes / No and CIRCLE or describe any issues that apply.	**Yes**	**No**
Ear, nose, throat problems (sinus, ear infection, chronic cough, dry mouth, etc.)____________________	☐	☐
Cardiac / Vascular problems (high blood pressure, heart pain, vascular disease, etc.):____________________	☐	☐
Respiratory problems (asthma, emphysema, use of CPAP machine etc.):____________________	☐	☐
Gastrointestinal problems (stomach ulcers, reflux, etc.):____________________	☐	☐
Genital, kidney or bladder problems:____________________	☐	☐
Muscle, bone or joint problems (arthritis, etc.):____________________	☐	☐
Skin problems (acne, warts, skin cancer, etc.):____________________	☐	☐
Neurological problems (multiple sclerosis, migraines, seizures, etc.):____________________	☐	☐
Psychiatric / social problems (anxiety, depression, bipolar, insomnia, etc.):____________________	☐	☐
Endocrine problems (diabetes, thyroid disorder, pituitary tumor, etc.):____________________	☐	☐
Blood/lymphatic problems (high cholesterol, anemia, etc.):____________________	☐	☐
Allergic/immune problems (hay fever, lupus, Sjogrens, etc.):____________________	☐	☐
Other:____________________	☐	☐

PLEASE TELL US IF YOU HAVE EVER… (Please answer and describe): **Yes No**

Sustained a head injury or trauma/stroke?______________________________ ☐ ☐

Been in a car accident?______________________________ ☐ ☐

Been diagnosed with Autism or Spectrum Disorder?______________________________ ☐ ☐

Been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD):______________________________ ☐ ☐

Been diagnosed with a learning disability or developmental disorder?______________________________ ☐ ☐

Had any surgeries?______________________________ ☐ ☐

Been diagnosed with cancer? What type?______________________________ ☐ ☐

ADDITIONAL MEDICAL INFORMATION

Primary Care Physician's Name:______________________________Clinic:______________________________

Last visit: ______________________________

What is your current height? feet inches

What is your current weight?__________pounds

Has a neurological evaluation ever been performed? ☐ Yes ☐ No

If yes, name and contact: ______________________________

List any medications you are allergic to:______________________________

List all prescription medications, vitamins, supplements, and over-the-counter medications you are taking:

Medicine	Dosage/ Frequency	Reason

GENERAL HEALTH AND LIFESTYLE INFORMATION

How often do you use tobacco products?

☐ Never ☐ Daily (>10/day) ☐ Daily (<10/day) ☐ Sometimes, not daily ☐ Former smoker

How often do you drink alcohol? ______________________________

How often do you use recreational drugs?______________________________

How many hours a day do you spend on screens (cellphone, tablet, computer, television)?__________________

Which of the following describes your diet?

☐ Excellent, a wide variety of foods are eaten from each food group daily

☐ Good, some items from each food group are apart of my weekly diet

☐ Poor, I only eat a select amount of foods and do not often eat from multiple food groups

Please circle all that apply to how you feel the majority of the time?

☐ Fatigue ☐ Average energy level ☐ High energy ☐ Relaxed ☐ Impulsive

☐ Irritable ☐ Happy ☐ Tense ☐ Frustrated ☐ Anxious ☐ Depressed

FAMILY MEDICAL HISTORY

Do your ***family members*** (grandparents, parents, siblings) have any of the following conditions?

	Yes	**No**	If so, who? M=mother, F=father, S=sibling, GP=grandparent
Blindness	☐	☐	____________
Glaucoma	☐	☐	____________
Cataracts	☐	☐	____________
Macular degeneration	☐	☐	____________
Eye turn (strabismus)	☐	☐	____________
Lazy eye (amblyopia)	☐	☐	____________
Retinal detachment	☐	☐	____________
Rheumatoid arthritis	☐	☐	____________
Cancer	☐	☐	____________
Diabetes	☐	☐	____________
High blood pressure	☐	☐	____________
Stroke	☐	☐	____________
Heart disease	☐	☐	____________

VISION SYMPTOMS:

Do you ***currently*** have any **vision-related issues**?

☐ Blurred vision
☐ Loss of vision
☐ Floaters in vision
☐ Eye turn
☐ Halos in vision
☐ Head tilt / face turn
☐ Double vision
☐ Flashes in vision
☐ Blind spots
☐ Lazy eye
☐ Light sensitivity
☐ Lose attention easily
☐ Motion sickness/ car sickness
☐ Discomfort with 3D movies
☐ Poor reading comprehension
☐ Poor tracking / eye movements

Do you ***currently*** have any **eye comfort-related issues**?

☐ Dry eye
☐ Eye pain
☐ Itchy eyes
☐ Red eyes
☐ Burning eyes
☐ Eye soreness
☐ Gritty/ sandy feeling
☐ Other: ______________________
☐ Tired eyes
☐ Watery eyes
☐ Mucous discharge

Do you ***currently*** have any **motor-related issues**?

☐ Poor motor control
☐ Trouble sitting still
☐ Trouble catching a ball
☐ Clumsy/ stumble easily
☐ Balance Issues

Do you ***currently*** have any neurological symptoms?

☐ Severe lethargy
☐ Severe neck stiffness
☐ Vertigo
☐ Speech difficulties
☐ Fainting or light-headness
☐ Vomiting during the night or upon waking
☐ Persistent hemifacial or hemicranial pain, numbness, pins and needles

DEVELOPMENTAL HISTORY (for patients under 18 years old)

Length of pregnancy:______________________________Child's birth weight: _____________________________

Type of delivery: ☐ Natural ☐ C-section ☐ Forceps/vacuum ☐

Anesthesia Child is: ☐ Biological ☐ Adopted ☐ Foster ☐ Other

During pregnancy of this child, did any of the following occur?

☐Toxemia trauma ☐ Injury by fall ☐ Severe fall ☐ Prescribed medication

☐Tobacco use ☐ Alcohol use ☐ Illicit drug use

Please explain:____

Please list any other complications during labor or when he/she was in utero:

____

Did he/she hit all developmental milestones at the appropriate time (creeping, crawling, walking, talking, etc.)?

☐Yes ☐ No Details:____

Please list any other developmental concerns:____

____

Has he/she experienced a traumatic event within the last year? ☐ Yes ☐ No If so, please explain:

____

Is the child especially afraid of doctors? ☐ Yes ☐ No

Does the child understand/ follow simple directions? ☐ Yes ☐ No

How does the child communicate? ☐ Verbal ☐ Communication Device ☐ ASL

☐ Other:_____________

What would you say your child's sociability is? ☐ Introverted ☐ Average ☐ Outgoing

Is he/she in extracurricular activities or playing sports? ☐ Yes ☐ No Activity/Sport: _______________________

____

Does he/she like school? ☐ Yes ☐ No

Which of these categories has the child mastered? ☐ Shapes ☐ Letters ☐Colors ☐Numbers

☐Reading How is he/she performing academically: ☐ Above average ☐ Average ☐

Below average

What subject(s) does your child struggle with? ____

____

Does your child have trouble focusing during school or at home? ☐ Yes ☐ No

If so, when? ____

Is your child in any other therapies or tutoring? ☐ Yes ☐ No

If so, name and contact: ____

____

May we collaborate with the above contact regarding your child's progress and challenge points? ☐ Yes ☐ No

SYMPTOM CHECKLIST

Please check the most appropriate box or circle the number that best matches your observations.

0: Never 1: Seldom 2: Occasionally 3: Frequently 4: Always

Headaches with reading and writing	0	1	2	3	4
Words run together or blur when reading	0	1	2	3	4
Eyes burn, itch, or water	0	1	2	3	4
Loses place while reading	0	1	2	3	4
Head tilt or closes one eye while reading	0	1	2	3	4
Hard to copy/read from board or distance	0	1	2	3	4
Does not like reading or writing	0	1	2	3	4
Leaves out small words when reading	0	1	2	3	4
Hard to write in a straight line	0	1	2	3	4
Misaligns digits/columns of numbers	0	1	2	3	4
Poor reading comprehension	0	1	2	3	4
Holds reading material very close	0	1	2	3	4
Hard to pay attention when reading	0	1	2	3	4
Hard to complete assignments/work tasks on time	0	1	2	3	4
Gives up easily	0	1	2	3	4
Clumsy, trips/bumps into things	0	1	2	3	4
Work/ visual tasks take a long time to complete	0	1	2	3	4
Daydreams	0	1	2	3	4
Forgetful/poor memory	0	1	2	3	4
Fatigue/falls asleep while reading	0	1	2	3	4

FINANCIAL POLICY

In order to reduce confusion and misunderstanding between the patients and the practice, we have adopted the following financial policy. If you have any questions, please feel free to ask management. Our goal is to
provide the best possible care for you and your family. A complete understanding of the financial policies below will help us to uphold that goal.

- Neuro Eye Team is an open access provider practice and payment is due at the time of service. For your convenience, we accept cash, checks, and credit/debit cards. Upon request, we can provide our patients with an itemized receipt to submit to insurance.
- We offer Care Credit as another payment option. It is a convenient, low minimum monthly payment program (6 months deferred interest) specifically designed to pay for healthcare and elective treatment not covered by insurance. Please ask us for more information or how to sign up.
- We will look to the guardian of the minor for consent and financials regarding any and all services rendered.
- There will be a $25 returned check fee for any checks returned by the bank.
- Our payment processing system does keep card information on file. We will always get prior consent before any charge.

My signature below confirms that I understand the above policies and that I am responsible for payment at the time of service.

Patient’s Printed Name:____

Patient/Guardian Signature and Date:____

RELEASE OF INFORMATION

I agree to permit information from my examination records, or copies of my records, to be forwarded to other healthcare providers or insurance carriers upon written request or upon the recommendation of Alex Conley, O.D. when it is necessary for the treatment of my visual condition, my treatment process with Neuro Eye Team.

Patient’s Printed Name:____

Patient/Guardian Signature and Date:____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Many of our patients allow family members or other medical professionals to call and request the results of tests, procedures and financial information. Under the requirements for H.I.P.A.A., we are not allowed to give this information to anyone without the patient's consent.

I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Neuro Eye Team. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to Neuro Eye Team at 6612 N Riverside Drive, Suite 130, Fort Worth, TX 76137. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I may contact the Neuro Eye Team office for answers to my questions about the privacy of my health information at (817) 928-3337 or office@neuroeyeteam.com.

I authorize the release of the following health information:

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]
- ❑ Only the following records or types of health information:________________________________

I authorize the release of my records and any information requested to the following individuals.

Name:________________________________Relation to Patient:____________________

Contact information: ____

Name:________________________________Relation to Patient:____________________

Contact information: ____

Name:________________________________Relation to Patient:____________________

Contact information: ____

Name:________________________________Relation to Patient:____________________

Contact information: ____

Authorization Regarding Messages (please check all that apply)

- ❑ I authorize you to leave a detailed message on my or the individuals listed above home or cell number regarding appointments.
- ❑ I authorize you to leave a detailed message on my or the individuals listed above home or cell number regarding medical treatment, care, test results or financial information.
- ❑ I authorize you to leave a message with anyone who answers the phone.

______________________________ ______________________________

PATIENT'S NAME PATIENT/GUARDIAN SIGNATURE

______________________________ ____________________

NAME OF PARENT/GUARDIAN DATE

[1]NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.

Patient Acknowledgment of Receipt of Notice of Privacy Practices

Please Print

I, ______________________________, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information:

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

Neuro Eye Team

(817)928-3337

office@neuroeyeteam.com

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature: ______________________________ Date: ___/___/___

Name: ______________________________
Please Print

Relationship to Patient: ______________________________

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of ______________________________'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

☐ Patient refused to sign (date of refusal) ___/___/___.

☐ Communications barriers prohibited obtaining an acknowledgment.

☐ An emergency situation prevented us from obtaining an acknowledgment.

☐ Other ______________________________

Attempt was made by: ______________________________ Date: ___/___/___

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ATTORNEY APPROVED