PATIENT INFORMATION – VTCC

Personal Contact information **Exam Date:**

Patient Name _____ Date of Birth _____

Address _____ _____City _____State_____Zip Code_____

Mother's Name:_____Father's Name:_____

Home Phone w area code (_____)_____**Mother's Cell Phone** (_____)_____ _____

Father's Cell Phone (_____)_____Father's/Mother's W Phone: _____

Mother's Email Address:_____@_____

Father's Email Address:_____@_____

Responsible Party's Driver's License Number:_____ Exp. Date_____ Mother / Father

School

Name of School_____ Address of School:_____

Grade_____Teacher(s)_____

Who Referred you to Dr. Haleo?

Referred By: (name) _____
❑OT ❑ST ❑PT ❑Friend ❑Another Patient ❑ Psychologist ❑Optometrist ❑ Family MD ❑Other Health Professional
❑ WebSite ❑ Internet ❑Optometrists Network C.O.V.D./N.O.R.A.

Medical Insurance

Insurance Company _____ _____Policy Number _____
Type of Coverage/Name of Plan (PPO, POP, HMO, Choice)_____

Healthcare Professionals Names & Addresses

Name & Address of Family Pediatrician/Physician

_____
_____
_____

Name & Address of Last Eye Doctor

_____
_____
_____

Name & Address of O.T.

_____
_____
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Name & Address of P.T.

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_____

Name & Address of Psychologist/Counselor

_____
_____
_____

Name & Address of Neurologist

_____
_____
_____

Name & Address of Speech Therapist

_____
_____
_____

Name & Address of Audiologist, ENT, Tutor, etc.

_____
_____
_____

Method of Payment Today: ❑ Check ❑ Money Order ❑ Credit Card

Notice of Privacy Practices - Effective Date: 01-03-07

By Signing below, I acknowledge that I have received the Vision Therapy Center's Privacy Practice Notice.

X_____ Date:_____

PAYMENT GUARANTEE AND RELEASE AUTHORIZATION

I hereby authorize the release of any medical information needed to process insurance claims. In addition, I hereby authorize the release of any medical information to my physician or referring healthcare provider. Any and all information shall remain confidential.

I understand and agree that I and not my insurance carrier are ultimately responsible for payment of services when rendered. I clearly understand that if due to nonpayment of materials or services, I agree to pay all costs incurred in the collection of the fees associated with providing such materials and services, including but not limited to, all reasonable attorney's fees, court costs, a monthly finance charge of 2.0% per month on any outstanding balance owed and/or a minimum late fee of $45.00 for each ten day period fees for services remain unpaid. Additionally, I recognize funds returned as "insufficient" by my financial institution will result in an additional charge of $45.00 for each occurrence.

Patient Signature/Responsible Party

X_____ Date:_____
Spouse Parent Daughter Son Legal Guardian Other

MEDICAL HISTORY / REVIEW of SYSTEMS

Name_____ DOB _____Date _____

Referred By:_____For: _____

PATIENT MEDICAL HISTORY

What is the primary reason for your visit today?

_____
_____
_____
_____

What is our child's general health status? ❑Excellent ❑Good ❑Fair ❑Poor

CHILD'S CURRENT WEIGHT: _____LBS CHILD'S CURRENT HEIGHT:_____FT_____INCHES

Does your child **have allergies to any medications**? ❑Yes ❑No ❑Sulfur Drugs ❑Penicillin ❑Other, explain:

_____

Does your child suffer from **seasonal allergies**? ❑Yes ❑No

Allergic to what? _____What happens? _____

CURRENT MEDICATIONS: List all medications your child is taking or suppose to be taking.

_____
_____

Major Surgeries/Hospitalizations

List all major illnesses, injuries, surgeries and/or hospitalizations since birth.

Date: _____
Date:_____
Date:_____

PATIENT/FAMILY MEDICAL HISTORY

Does YOUR CHILD or anyone in your family have any of the following: (including parents, grandparents, siblings, etc.)

		Relationship
ADHD	❑Yes ❑No	_____
Arthritis	❑Yes ❑No	_____
Anxiety	❑Yes ❑No	_____
Asthma	❑Yes ❑No	_____
Cancer	❑Yes ❑No	_____
Cholesterol	❑Yes ❑No	_____
Depression	❑Yes ❑No	_____
Diabetes	❑Yes ❑No	_____
Head Injury	❑Yes ❑No	_____
Heart Disease	❑Yes ❑No	_____
High Blood Pressure	❑Yes ❑No	_____
Hyperactivity	❑Yes ❑No	_____
Kidney Disease	❑Yes ❑No	_____
PDD	❑Yes ❑No	_____
Stroke	❑Yes ❑No	_____
Thyroid Disease	❑Yes ❑No	_____
Genetic/Hereditary	❑Yes ❑No	_____

OTHER: My child has been diagnosed with:

_____
_____
_____
_____
_____
_____
_____
_____

Dr.'s Review_____

PATIENT MEDICAL EYE HISTORY

How many years since YOUR CHILD'S last eye examination. NEVER <1 1-3 4-10 >10

By whom/where: _____

Has your child ever been diagnosed OR treated for:

❑Amblyopia ❑Blindness ❑Cataracts ❑Corneal Inj. ❑ Color Deficiency
❑Crossed Eye ❑Dry eye ❑DoubleVision ❑Eye infection ❑Eye injury
❑Glaucoma ❑Headaches ❑Head Injury ❑Itchiness ❑Iritis
❑Lazy eye ❑Macular Degen. ❑Strabismus ❑Blurry vision ❑ Retinal Disease
❑Scratched Cornea ❑Focusing problems ❑Eye tracking prob

Does your child report any of the following symptoms with their eyes?

❑Burning sensation ❑Tearing ❑ Sandy feeling in eyes ❑Flashes of Light Seeing floaters
❑Dryness ❑Sunlight sensitivity ❑ Trouble seeing ❑Eye strain & discomfort

FAMILY EYE HISTORY Please indicate if any member of your family has been diagnosed with:

❑ Amblyopia ❑ Cataracts ❑ Corneal Disease ❑ Color Deficiency ❑ Dry eye/Sjogren's
❑ Diabetes of the eye ❑ Glaucoma ❑ Lazy eye ❑ Macular Degeneration ❑ Retinal Disease
❑ Strabismus ❑ Convergence ❑ problems ❑ Tracking problems ❑ OTHER

Developmental INFANT/TODDLER/CHILD HISTORY

Is this your natural child? ❑ Yes ❑ No_____
Was this a full term pregnancy? ❑ Yes ❑ No_____
Any complications? ❑ Yes ❑ No_____
Did your child ever receive oxygen as an infant? ❑ Yes ❑ No_____
CHILD'S SIBLINGS: NAME:_____AGE:_____NAME:_____AGE:_____
NAME:_____AGE:_____NAME:_____AGE:_____

Has your child ever received a developmental assessment? ❑ Yes ❑ No

By Whom:_____Where:_____When _____

Has your child ever received a Visual Perceptual Developmental assessment? ❑ Yes ❑ No

Are there specific developmental delays you know about? ❑ Yes ❑ No If yes, please list: _____
Has your child had chronic ear infections? ❑ Yes ❑ No
Has your child had chronic respiratory infections? ❑ Yes ❑ No
Has your child had tubular implants in the ear canals? ❑ Yes ❑ No
Is your child receiving any tutoring? ❑ Yes ❑ No
Is your child currently receiving any other THERAPY? ❑ Yes ❑ No

❑ OT ❑ PT ❑ ST ❑ MT ❑ VT ❑ Tutoring
Number of times/wk ❑ 1 ❑ 2 ❑ 3 ❑ 4
How long have they been receiving this therapy_____

EYE MEDICINES, EYE SURGERIES, TREATMENTS

List any and all Prescription or Nonprescription eye drops your child currently uses:

_____
_____

List all past eye diseases, eye injuries or eye surgeries your child has had.
Date:_____
Date:_____

Dr.'s Review_____

PATIENT EYE GLASSES & CONTACT LENSES HISTORY

CHILDREN

1. Does your child NOW wear eyeglasses? ❑ Yes ❑ No
2. Were glasses ever prescribed? ❑ Yes ❑ No

If yes, please specify for what purpose:

❑ Full time ❑ Only when in school ❑ Reading ❑ Writing ❑ Copying from the board ❑ Homework
❑ Sports ❑ Playing ❑ Around the House ❑ TV ❑ For the computer

3. Did YOUR CHILD'S last eye doctor prescribe **more than one pair** of glasses? ❑ Yes ❑ No
4. Are the current glasses YOUR CHILD have contain lenses that are:

❑ SINGLE VISION ❑ BIFOCAL ❑ INVISIBLE BIFOCALS ❑ PHOTOCHROMIC ❑ POLYCARBONATE
❑ HAVE NO IDEA

5. Does your child wear contact lenses? ❑ Yes ❑ No
6. If yes, how often are they replaced?
   ❑ Daily ❑ Weekly ❑ Every 2 weeks ❑ Monthly ❑ Quarterly ❑Yearly
7. Do your child's contact lenses correct for astigmatism?
   ❑ Yes ❑ No ❑ Don't Know

VISION THERAPY TREATMENT

1. Has your child ever received vision therapy? ❑ Yes ❑ No

From: _____To:_____

Name of PROVIDER:_____

2. Was it successful? ❑ Yes ❑ No

If so, what gains were made?

_____
_____
_____

If not, what gains did you hope to accomplish?

_____
_____
_____

PLEASE LIST YOUR CHILD'S HOBBIES, SPORTS, CRAFTS, etc... Anything that brings your child joy!

_____
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Dr.'s Review_____

MEDICAL HISTORY / REVIEW of SYSTEMS

SOCIAL HISTORY (This information is a protected part of your medical record. It is confidential.)
Does your child's vision limit activities of daily living? (reading, learning, playing etc) ❑ Yes ❑ No
If yes, please describe._____
_____
_____

1. Living Arrangements Lives with both parents Lives w/ one parent most of the time Lives w/ grandparents
Other_____
2. To the best of your knowledge, does your child use alcohol, tobacco or drugs? ❑ Yes ❑ No
3. To the best of your knowledge, has your child ever been physically or sexually abuse? ❑ Yes ❑ No
4. Has your child **ever been exposed to or infected with**: ❑ HIV ❑ Hepatitis ❑Tuberculosis ❑STD's

REVIEW of SYSTEMS Please indicate if **your child** currently has any problems in one or more of the following areas

GENERAL / CONSTITUTIONAL ❑ Yes ❑ No
(fever, weight loss or gain, tired feeling)
_____

EYES ❑ Yes ❑ No
(blurred vision, eye pain, discharge, dry eye, sandy gritty feeling, etc)
_____

EARS, NOSE, THROAT, MOUTH ❑ Yes ❑ No
(hearing loss, ear ache, nasal congestion, chronic cough, nasal drip, dry mouth, allergies, hay fever, etc.)
_____

ENDOCRINE ❑Yes ❑ No
(diabetes, thyroid, etc.)
_____

RESPIRATORY ❑ Yes ❑ No
(asthma, emphysema, chronic bronchitis, wheezing, shortness of breath, etc.)
_____

CARDIOVASCULAR ❑ Yes ❑ No
(diabetes, hypertension, heart problems)
_____

GASTROINTESTINAL ❑Yes ❑ No
(diarrhea, constipation, hernia, ulcers, etc.)
_____

GENITOURINARY ❑ Yes ❑ No
(painful urination, frequent urination, impotence, jaundice, etc.)
_____

LYMPHATIC ❑ Yes ❑ No
(anemia, bleeding problems, problems, with blood transfusions, etc.)
_____

MUSCULOSKELETAL ❑ Yes ❑ No
(arthritis, joint pain, muscle pain, cramps, stiffness, swelling. etc.)
_____

NEUROLOGICAL ❑ Yes ❑ No
(Dizziness, falling, bumping into things, headaches)
_____

PSYCHIATRIC / EMOTIONAL ❑ Yes ❑ No
(Anxiety, depression, hallucinations, memory loss, disorientation, paranoia)
_____

SKIN ❑ Yes ❑ No
(pimples, warts, growths, rashes, etc.)
_____

Doctor's Additional Comments/Notes:
Patient appeared oriented to place & time ❑ Yes ❑ No

_____
_____

Dr.'s Review_____

Parent's Additional Comments/Notes:

____

____

____

____

____

Parent/Patient Goals: What do you hope to gain from this evaluation today?

1. ____
2. ____
3. ____
4. ____
5. ____

X____

Please sign. Relationship to child: Mother Father Grandparent Legal Guardian Other

PLEASE DO NOT WRITE IN THIS SECTION

Doctor's Additional Comments/Notes:

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____Dr.'s Review__________

Vision Therapy Center of Charlotte, LLC.

888-262-2020 3686 Center Circle Drive Fort Mill, SC 29715 803.802.7171

S T E V E N L. H A L E O, O.D., F.C.O.V.D.

Dear Parent,

In an effort to ensure the most thorough examination of your child, please fill out the attached **FUNCTIONAL VISUAL ABILITIES** checklist prior to your visit. Bring the completed form with you at your visit with Dr. Haleo. This will help save *valuable time* for you and allow Dr. Haleo to better concentrate his efforts on your child.

Additionally, please make a copy of the checklist on the next page and give one of these checklists to **your child's educators** and other health care providers such as their OT, PT, etc. Their observations are very powerful and often helpful in better understanding your child.

If you have any questions, please don't hesitate to contact us at 803.802.7171.

Thank you.

Dr. Haleo
Dr. Steven L. Haleo, O.D., F.C.O.V.D.
Board Certified & Fellowship Trained in
Binocular Vision, Vision Perception &
Neuro-Optometric Rehabilitation

Vision Therapy Center of Charlotte, LLC. Steven L. Haleo, O.D., F.C.O.V.D.

3686 Center Circle Fort Mill, SC 29715 803.802.7171 888.262.2020

Checklist of Observable Signs, Symptoms & Clues to Children's Vision Acquisition & Visual Perceptual Problems in the Classroom

Child's Name: _____ D.O.B._____ Date:_____

EYE MOVEMENT, EYE FOCUSING & EYE AIMING ABILITIES

- ☐ Homework is difficult
- ☐ Homework takes longer than it should
- ☐ Print blurs after reading a short time
- ☐ Complains of seeing double (diplopia)
- ☐ Words move or "swim" on the page
- ☐ Gets sleepy after reading or copying for a short time
- ☐ Head turns as reads across page
- ☐ Loses place frequently during reading
- ☐ Needs finger or marker to keep place
- ☐ Short attention span in reading or copying
- ☐ Frequently omits words
- ☐ Quickly loses interest in reading
- ☐ Rereads or skips lines unknowingly
- ☐ Makes errors in copying from board to paper
- ☐ Makes errors in copying from page to page
- ☐ Squints to see chalkboard, or requests to move nearer
- ☐ Repeats letters within words
- ☐ Avoids reading
- ☐ Omits letters, numbers or phrases

EYE-HAND COORDINATION ABILITIES

- ☐ Writes crookedly, poorly spaced; cannot stay on lines
- ☐ Must feel things "to get the idea"
- ☐ Writes up or downhill on paper
- ☐ Orients drawings poorly on page
- ☐ Eyes not used to "steer" hand movements (extreme lack of orientation, placement of words or drawings on page)
- ☐ Misaligns horizontal & vertical series of numbers
- ☐ Repeatedly confuses left-right directions

VISUAL PERCEPTION (Visual Imagery, Visualization)

- ☐ Fails to follow directions
- ☐ Fails to picture what is read silently or aloud
- ☐ Directions need to be repeated many times
- ☐ Math concepts difficult
- ☐ Math word problems difficult
- ☐ Spelling is difficult
- ☐ Spells well then cannot recall words during tests
- ☐ Fails to recognize same word in next sentence
- ☐ Reverse letters and/or words in writing and copying
- ☐ Difficulty recognizing minor differences
- ☐ Repeatedly confuses words with similar beginnings and endings
- ☐ Whispers to self for reinforcement while reading silently
- ☐ Uses "drawing with fingers" to discriminate similarities and differences

APPEARANCE OF EYES

- ☐ One eye turns in or out at any time
- ☐ Reddened eyes or lids
- ☐ Squints, closes or covers one eye
- ☐ Eyes tear excessively
- ☐ Encrusted eyelids
- ☐ Frequent styes on lids

COMPLAINTS WHEN USING EYES AT DESK

- ☐ Blinks excessively at desk tasks or reading
- ☐ Headaches in forehead or temples
- ☐ Burning or itchy eyes after reading or homework
- ☐ Tilts head extremely while working at desk
- ☐ Odd working posture at desk activities
- ☐ Holds book too closely; face too close to desk
- ☐ Rubs eyes during/after short periods of visual activity
- ☐ Blinks to clear focus after reading or writing

Professional Use by ☐OT ☐PT ☐ SP ☐Psych/Counselor ☐ Teacher ☐Tutor ☐ MD ☐ Audiologist ☐OD

Tracking Problems Tested/Detected: ☐Yes ☐ No

NPC test performed/Problem Detected: ☐Yes ☐ No

Additional Observations and Comments:

_____
_____
_____
_____
_____
_____

Your Name: _____

Email: _____

Phone: _____

Vision Therapy Center of Charlotte, LLC. Steven L. Haleo, O.D., F.C.O.V.D.

3686 Center Circle Fort Mill, SC 29715 803.802.7171 888.262.2020

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

The purpose for the release: To facilitate and better communicate the treatment of me or my child. This release shall expire one year from the date of signature unless otherwise noted

Patient Name:
DOB:
Street address:_____
City, State, Zip: _____

I authorize the professional office of my optometrist, Dr. Steven L. Haleo to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. Detailed description of the information to be released
   ❑ Medical Diagnosis ❑ Treatment Dates, Plan and progress ❑ Other:_____
2. To whom may the information be released: ❑ School ❑ Tutor ❑ OT ❑ PT ❑ MD ❑ Speech Therapist ❑ Counselor ❑ Psychologist ❑ Other:_____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. You can also review your health information that we have before deciding whether to sign this authorization. Our Notice of Privacy Practices explains how to request access to your identifiable health information, and how we may respond. Basically, you simply need to send a written request to the Chief Compliance Officer listed at the top of this form to initiate the process.

If you sign this authorization, you can revoke it later. The exceptions to this are if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked. Send this note to the Chief Compliance Officer listed above.

When your health information is disclosed as provided in this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes. We *will not* receive a financial benefit from disclosing this health information about you.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient:
❑ Mother ❑ Father ❑ Legal Guardian ❑ Immediate Family Relative

Source of your authority to sign this form:
❑ Mother ❑ Father ❑ Legal Guardian ❑ Immediate Family Relative

Print name_____

Signature:_____Date:_____