HEARTLAND EYE CONSULTANTS

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

To Our Valued Patient:

Welcome to Heartland Eye Consultants! We are looking forward to seeing you and your child for their appointment. Please fill out the New Patient paperwork. We would greatly appreciate your taking the time to fill out these forms at home. This will save valuable time in-office and make available more time with your doctor. Please bring them with you to your appointment.

Please bring the following with you to your appointment:

1. The enclosed Patient Information Forms:
2. Your child's insurance card
3. Your child's co-pay
4. A list of any medications your child takes with the dosages
5. Your child's glasses (Even if they do now wear them)

Please note that all co-payments and applicable yearly deductibles are due at the time of your visit. Please make sure you have a credit card, your check book or cash with you.

This examination will NOT be considered a ROUTINE visit so we will be submitting to your major medical insurance, not your 'vision' or 'eye glasses' insurance.

If your child's insurance requires a referral from your primary care doctor (pediatrician or family doctor, *not* your eye doctor), it is your responsibility to request the referral **before** your appointment at Heartland Eye Consultants. If that is not done **by you** ahead of time, we may have to reschedule your appointment because some doctor's require a day's notice or more to get those completed and faxed to us.

Handicapped Parking and Senior Parking is available on the **west** side of the building. Parking there will eliminate the need to climb stairs.

If you have any questions or need to reschedule your appointment, please call us at (402)493-6500. Thank you for entrusting your vision to us!

Sincerely,
Patient Services

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 _____ ___
Years Months

☐ Male ☐ Female Grade___________ Reading Level ______

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

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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): 92004
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
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 except Blue Cross Blue Shield.*** This means that, for patients with other insurances, all fees will be paid by the patient and any reimbursement from the insurance company will be paid directly to the patient.

The codes for therapy for Developmental Vision Associates (Tax ID# 20-8120553) are as follows:

97530, 97532, 97110, 97112

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: 92004 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 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