SCREENING QUESTIONNAIRE

Binocular Vision Dysfunction

For ages 13 & younger

Name: _____ Email: _____

Phone Number: _____ Today's Date: _____

Directions: For each of the following questions, please check the answer that best describes your situation. If you wear glasses or contact lenses, answer the questions assuming that you are wearing them.

Always = every day Frequently = at least once/week

Occasionally - less than once/week Never = never

		ALWAYS	FREQUENTLY	OCCASIONALLY	NEVER
1	Do you have headaches or face pain?				
2	Do your eyes hurt and/or does it hurt to move your eyes?				
3	Do you have neck pain, a stiff neck or upper back pain?				
4	Do you have stomach aches or nausea?				
5	Do you get car sickness or motion sickness?				
6	Do you experience dizziness, light headedness, or nausea while performing far-distance activities (driving, television, movies, etc.)?				
7	Do you get sick to your stomach or nauseous on swings or circular rides?				
8	Does riding in the car give you headaches or stomach aches?				
9	Do you have trouble reading in the car?				
10	Do you feel clumsy, klutzy or uncoordinated?				
11	When you are walking, do you bump into people, furniture, or door frames?				
12	Do you feel funny or dizzy when you bend over and stand back up quickly?				
13	Are you anxious or nervous?				
14	In grocery stores or malls, do you stay close (cling) to your parent/guardian? (Do you feel uncomfortable in grocery stores or malls?)				
15	Do you tend to play alone or with just a few other kids? (Do you tend to play apart from the main group of kids?)				
16	Is reading hard for you or are you a slow reader?				
17	Do you have to read the same thing a couple of times to really understand it?				
18	Do you use your finger, ruler or a piece of paper to help you keep your place when you are reading?				
19	Do you skip lines or lose your place when you are reading?				
20	When you read, does it look like the letters are moving or does it seem like words are bumping into each other?				
21	Do bright lights hurt your eyes?				
22	Do you close or cover one eye to make it easier to see?				
23	Do you have trouble catching baseballs, footballs, or Frisbees?				
24	Do you ever see two of everything (double vision)?				
25	Is it hard for you to watch 3-D movies?				
26	When reading or working on the computer, do your eyes feel tired or does your vision get blurry?				
27	When looking at the blackboard at school, do your eyes feel tired or does your vision get blurry?				

This questionnaire is designed to screen for those who may have di culty with vision alignment. The information obtained herein is considered a preliminary result only and does not diagnose or constitute con rmation of any vision problems. It is not a substitute for a NeuroVisual examination. Since vision changes can occur without visible indications, most eye care professionals and medical authorities recommend a vision exam annually.

Parent/Guardian: Has your child ever been diagnosed with:			
Learning Disability (LD)?	Yes	No	
Dyslexia?	Yes	No	
Torticollis?	Yes	No	
Lazy eye?	Yes	No	
ADD / ADHD?	Yes	No	
Migraines or headache disorder?	Yes	No	
Traumatic brain injury or Concussion?	Yes	No	
Does your child blink his/her eyes a lot (much more than most children)?	Yes	No	
Are your child's verbal skills far ahead of his/her reading skills?	Yes	No	
Has your child ever had an eye operation?	Yes	No	

On an average day, how much are you bothered by the symptoms listed below? Rate each symptom from 0 - 10, where 10 = the worst it could be and 0 = you do not experience that symptom.		Please record any additional symptoms you may be experiencing or specific concerns that you have about your eyes and/or vision:
Dizziness	_____ / 10	
Nausea	_____ / 10	
Anxiety	_____ / 10	
Headache	_____ / 10	
Neck ache	_____ / 10	
Unsteady with walking	_____ / 10	
Sensitivity to light	_____ / 10	
Reading difficulty	_____ / 10	

This questionnaire is designed to identify individuals whose symptoms (ex: headache, dizziness, anxiety, etc.) may be due to vision misalignment.

How to score this questionnaire:

For questions 1-27, scoring is as follows (see below). Add the scores for questions 1-27 to get a TOTAL Score:

Always =	3
Frequently =	2
Occasionaly =	1
Never =	0

Consider an examination by a NeuroVisual Specialist if: Your TOTAL Score is 15 or greater OR you answered 'Always', Frequently', or 'Occasionally' to any of the following items: 2, 11, 19, 20, 22, or 24.

TODAY'S VISION dba TYLER EYECARE

Name: _____ M___F___ Single___Married___Other___DOB_____Email_____

Street: _____City_____State____ Zip_____SSN#_____

Daytime Phone# _____Home# _____ Cell# _____ OK to text message ☐

Occupation _____ Employer _____

Emergency Contact _____ Emergency Contact # _____

Payment Policy: It is customary to pay for professional service when rendered. For all insufficient funds checks an additional fee will be applied of $50.00 plus balance due.

Appointment Policy: Our office charges $30.00 for missed appointments and appointments cancelled without 24 hours notice. This fee is not billable to insurance _____**Initial**

Consent to Treatment and Authorization of Charges: I am and adult 18 years of age or older, or am the parent/guardian of the minor child whose name appears below and hereby authorize TODAY'S VISION dba TYLER EYECARE to perform such eye care and treatment on me or my minor child as it deems appropriate and consent to such care and treatment. I further authorize my child to order and purchase goods and services and agree to pay for them whether performed on me or my child. _____ **Initial**

Assignment of Benefits: I hereby assign payment of authorized insurance to which I am entitled to be made to TODAY'S VISION dba TYLER EYECARE for any goods or services furnished. I also authorize TODAY'S VISION dba TYLER EYECARE to release medical information to my insurance company (ies) now or in the future for claim consideration purposes. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that the filing of a claim for any services rendered **does not guarantee payment** from my insurance company. I understand that if my comprehensive routine exam is covered by my medical and vision insurance, this clinic's policy is to bill medical insurance first. I fully understand that I am financially responsible for all charges whether or not paid by said insurance (s). I hereby authorize said assignee to release all information necessary to secure the payment. _____ **Initial**

Payments with Insurance: Our staff will assist you in the dealing with your insurance company by verifying your benefits using the member services phone number given on your insurance card; however, **this verification is not a guarantee of payment, and it is your responsibility to know and understand your own insurance benefits, coverage and authorization requirements.** Additionally, all amounts owed by patient under contracted insurance plans (co-pays, deductibles and non-covered services) are payable at the time of service. **Any service that is rendered by this office, which is not a covered benefit under your insurance policy, is your responsibility to pay.** In order to process your insurance claim, you must present your insurance card or voucher at the time of service. Failure to do so may result in denial of your claim.

OPTOMAP RETINAL SCREENING AND DILATION CONSENT

A Dilated Fundus Exam is recommended during your vision examination. Dilation allows the Doctor a better view of your retina. This allows the Doctor to screen for problems that can occur due to systemic diseases such as diabetes and hypertension, along with eye issues such as glaucoma, macular degeneration, and cataracts. Dilation can blur your vision and make you sensitive to lights. Pupil size generally begins to reduce in about two hours. Any lasting effects such as redness and swelling or ocular pain should be reported as soon as possible. Dilation may also assist in determining the final glasses prescription, especially in young children.

The benefits of the **OPTOMAP Retinal Screening** include an in depth digital view of nearly the entire retina and it provides a permanent record to compare and track potential eye diseases. **OPTOMAP Retinal Screening** fees are **$39.00.** Insurance does not cover this service and it is not included in the examination fees. In some cases, a patient may have a medical condition that warrants doing the higher mode **OPTOMAP Plus** exam for which our office charges $80.00. The higher mode **OPTOMAP Plus** exam is covered by most medical insurance companies.

_____ _____ _____

Signature of Patient or Authorized Representative | Print Name | Date

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Today's Vision Tyler make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that:

☐ I have read, had explained to me, or was given an opportunity to read Today's Vision Tyler's Notice of Privacy Practice and agree to continue my care with Today's Vision Tyler under said terms.

☐ I authorize the release of information including the diagnosis, exam records and claims information rendered to me. I authorize the release to the following person/persons.

1. _____ Spouse/Family/Friend
2. _____ Spouse/Family/Friend

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient (print name) Date

_____ _____
Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____
Representative Relationship to Patient

Today's Vision
Contact Lens Evaluation

Your total contact lens fees are determined by the complexity of your prescription and the type of lenses designed for your specific vision needs. The total fee is based on three components*:

1. Examination Services
A comprehensive eye examination is required prior to placing any diagnostic lenses on your eyes. This evaluation is necessary to establish your baseline prescription, and to determine if the ocular structures are healthy and can support safe and comfortable lens wear.

2. Contact Lens Design & Follow-up Services
With recent advances in technology, most patients have the opportunity to wear contact lenses. The more complex the lens specifications are the more services are required to provide you with lenses that fit properly and perform well on your eyes. These services include: diagnostic assessment of lenses; lens design determination and calculations; laboratory ordering, inspection, and verification; a care and handling training visit; and finally, all required office visits.

3. Contact Lens-Diagnostic Materials (Trial Lenses)
We are committed to excellence in contact lens care. Your doctor will provide you with specific recommendations regarding the replacement schedule for your contact lenses, in addition to instructions on contact lens care. It is important to note that contact lens prescriptions expire in one year as mandated by federal law, and Dr. Neshia Rudd/Dr. Josh Hooper will need to see you again in one year to check that your eyes remain healthy for continued safe lens wear.

Fees- Range from $85-$225 for soft disposable contact lenses

Your signature below serves as your acknowledgment and understanding of the customary fees for contact lens services, and your willingness to adhere to the recommended wearing schedule that Dr. Neshia Rudd/Dr. Josh Hooper will prescribe.

Patient: _____
Date: _____

Thank you for trusting us with your contact lens care.

CASE HISTORY SUPPLEMENT FOR SCHOOL-AGE CHILDREN

Patient: _____ Date: _____

Completed By: _____

Please check any of the signs and symptoms that apply to this child:

- ☐ Short attention span, easily distracted, or extensive daydreaming
- ☐ School performance not up to potential.
- ☐ Reading below grade level.
- ☐ Had special education testing or receives special education services
- ☐ Poor reading comprehension
- ☐ Difficulty with word recognition
- ☐ Reversals (b for d, p for q, was - saw, on - no) when reading or writing
- ☐ Transposition of letters or numbers (21 for 12)
- ☐ Failure to complete work in allotted time
- ☐ Errors in copying from blackboard to paper
- ☐ Poor printing or handwriting
- ☐ Mistakes words with similar beginnings or endings
- ☐ Confuses similar words
- ☐ Fails to recognize same word in next sentence
- ☐ Uses finger or marker to keep place when reading
- ☐ Often loses place, skips or rereads words and/or letters when reading
- ☐ Complains of blurred vision during reading or writing, or when looking up from desk
- ☐ Complains of headaches associated with visual tasks
- ☐ Complains of print moving around or running together
- ☐ Complains of seeing double
- ☐ Closes or covers one eye in bright light or during visual tasks
- ☐ Reports feeling that eyes do not seem to be working together
- ☐ Experiences unusual fatigue after visual concentration
- ☐ Reports eyes hurt, burn, or tire while reading
- ☐ Experiences rubbing, blinking, or tearing of eyes
- ☐ Squints or frowns when doing visual work closer than arm's length away
- ☐ Tilts or turns head excessively when doing visual tasks
- ☐ Avoids near work such as reading, writing or written math problems