

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 after 9:00am the day of the appointment will result in a \$50.00 cancellation fee, unless the cancellation is due to an extenuating circumstances that have 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: _____
Patient's occupation: _____
Patient's employer: _____
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

Are you pregnant or nursing? Yes No If yes, when is due/birth date? _____

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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye turn (strabismus)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy eye (amblyopia)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

VISION SYMPTOMS:

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Double vision | <input type="checkbox"/> Motion sickness/ car sickness |
| <input type="checkbox"/> Loss of vision | <input type="checkbox"/> Flashes in vision | <input type="checkbox"/> Discomfort with 3D movies |
| <input type="checkbox"/> Floaters in vision | <input type="checkbox"/> Blind spots | <input type="checkbox"/> Poor reading comprehension |
| <input type="checkbox"/> Eye turn | <input type="checkbox"/> Lazy eye | <input type="checkbox"/> Poor tracking / eye movements |
| <input type="checkbox"/> Halos in vision | <input type="checkbox"/> Light sensitivity | |
| <input type="checkbox"/> Head tilt / face turn | <input type="checkbox"/> Lose attention easily | |

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

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Dry eye | <input type="checkbox"/> Burning eyes | <input type="checkbox"/> Tired eyes |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Eye soreness | <input type="checkbox"/> Watery eyes |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Gritty/ sandy feeling | <input type="checkbox"/> Mucous discharge |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Other: _____ | |

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

- | | |
|--|---|
| <input type="checkbox"/> Poor motor control | <input type="checkbox"/> Clumsy/ stumble easily |
| <input type="checkbox"/> Trouble sitting still | <input type="checkbox"/> Balance Issues |
| <input type="checkbox"/> Trouble catching a ball | |

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

- | | |
|--|--|
| <input type="checkbox"/> Severe lethargy | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Severe neck stiffness | <input type="checkbox"/> Speech difficulties |
| <input type="checkbox"/> Fainting or light-headedness | |
| <input type="checkbox"/> Vomiting during the night or upon waking | |
| <input type="checkbox"/> Persistent hemifacial or hemicranial pain, numbness, pins and needles | |

Vision Symptoms Survey

Please check the most appropriate box or circle the item number that best matches your observations. All information will be held in confidence.

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

EYESIGHT CLARITY	
Distance vision blurred and not clear (even with lenses)	0 1 2 3 4
Near vision blurred and not clear (even with lenses)	0 1 2 3 4
Clarity of vision changes or fluctuates during the day	0 1 2 3 4
Poor night vision/ can't see well to drive at night	0 1 2 3 4
VISUAL COMFORT	
Eye discomfort/ sore eyes/ eyestrain	0 1 2 3 4
Headaches or dizziness after using eyes	0 1 2 3 4
Eye fatigue/ very tired after using eyes all day	0 1 2 3 4
Feel "pulling" around the eyes	0 1 2 3 4
HEADACHES	
Frequency	0 1 2 3 4
Severity	0 1 2 3 4
Location?	
Do they wake you up at night?	
Do you experience migraines?	
DOUBLING	
Double vision (especially when tired)	0 1 2 3 4
Have to close or cover one eye to see clearly	0 1 2 3 4
Print moves in and out of focus when reading	0 1 2 3 4
LIGHT SENSITIVITY	
Normal indoor lighting is uncomfortable- too much glare	0 1 2 3 4
Outdoor light too bright - have to use sunglasses	0 1 2 3 4
Indoor fluorescent lighting is bothersome or annoying	0 1 2 3 4
DRY EYES	
Eyes feel "dry" and sting	0 1 2 3 4
"Stare" into space without blinking	0 1 2 3 4
Rub eyes a lot	0 1 2 3 4

Vision Symptoms Survey Continued

Please check the most appropriate box or circle the item number that best matches your observations. All information will be held in confidence.

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

DEPTH PERCEPTION	
Clumsiness/ misjudge where objects really are	0 1 2 3 4
Lack of confidence walking/ missing steps/ stumbling	0 1 2 3 4
Poor handwriting (spacing, size, legibility)	0 1 2 3 4
PERIPHERAL VISION	
Side vision distorted/ objects move or change position	0 1 2 3 4
What looks straight ahead, isn't always straight ahead	0 1 2 3 4
Avoid crowds/ can't tolerate "visually-busy" places	0 1 2 3 4
Loss of field of vision?	0 1 2 3 4
READING	
Short attention span/ easily distracted when reading	0 1 2 3 4
Difficulty/ slowness with reading and writing	0 1 2 3 4
Poor reading comprehension/ can't remember what was read	0 1 2 3 4
Confusion of words/ skip words during reading	0 1 2 3 4
Lose place/ have to use finger not to lose place when reading	0 1 2 3 4
MOUTH AND JAW	
Trouble Breathing	0 1 2 3 4
Snoring	0 1 2 3 4
Grinding/ Clenching Teeth Awake or Sleeping	0 1 2 3 4
Jaw Pain	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

¹NOTE: 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
RECEIVED

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date _____ Patient Name: _____ Date of Birth: _____

**Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.**

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all

Somewhat difficult

Very Difficult

Extremely Difficult

**Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.**

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all

Somewhat difficult

Very Difficult

Extremely Difficult

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