HEARTLAND EYE CONSULTANTS

9900 Nicholas Street ○ Suite 250 ○ Omaha, NE 68114
402-493-6500 ○ 888-837-3937 (EYES) **○ Fax: 402-493-4370**

To Our Valued Patient:

Thank you for choosing Heartland Eye Consultants! We are looking forward to seeing you for your appointment. Enclosed you will find a location map and a couple of forms. 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. You may mail or fax them back to us or bring them with you to your appointment, if there is not sufficient time for mailing.

Your appointment is on ______________________ at __________AM PM.

Please bring the following with you to your appointment:

1. The enclosed Patient Information Forms
2. The History form
3. Your insurance card
4. Your co-pay
5. A list of any medications you take with the dosages
6. Your glasses

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 using your major medical insurance, not your ‘eye’ or ‘eye glasses’ insurance.

If your 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 or 888-837-3937. Thank you for entrusting your vision to us!

Sincerely,

Patient Services

Heartland Eye Consultants
Pediatric Patient Demographics

Patient:

Last Name:_______________________________First Name:___________________________ M.I._____

Street Address:____________________________Apt #______ Gender: M F **Date of Birth**:___/___/_______

City: _____________________ State:_____ Zip Code:_______Soc. Sec. No. ____-____-_______ **Age** ______

Which doctor referred you to our office?____________________________ If not, please list______________________

Who performed your last eye exam? ____________________________ Date: ____/____/____

Pediatrician/Family Physician: _____________________________M.D.

Name of 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:_______

When we contact you to confirm or change an appointment, which method(s) do you prefer? (Please place an X in the circles.)

○Call ○Text Cell Phone: (___)_____________ ○Home Phone:(____)___________

○Work Phone_________ ○Email Address: ______________________

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:_______

When we contact you to confirm or change an appointment, which method(s) do you prefer? (Please place an X in the circles.)

○Call ○Text Cell Phone: (___)_____________ ○Home Phone:(____)___________

○Work Phone_________ ○Email Address: ______________________

SSN:_________________ Employer: ______________ Occupation________________Title: ____________

Employer's Address:________________ City______________State______Zip_______ Work Phone_________

☐Step-Father's Last Name: _________________ First Name:______________M.I.___ Birthdate: ____/____/___

☐Step-Mother's Last Name: _________________ First Name:_____________M.I.___ Birthdate: ____/____/___

<u>The person requesting services for a minor is the responsible party.</u>

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 YOU 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. 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.
A copy of my child's medical records can be requested in writing and will be provided to me or whomever I designate for $15.00. There is a $25.00 fee for returned checks.

Authorized Signature: _______________________________________Date of Signature: ______________

Heartland Eye Consultants
9900 Nicholas Street, Omaha, NE 68114 (402)493-6500 Fax: (402-493-4370

CHILDREN'S STRABISMUS/AMBLYOPIA 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 Dr. Vandervort to better understand your child's condition.
Please mail or fax this form to us or bring it with you to your appointment. Thank you!

Appointment: ____________________________________
Day Date Time

CHILD'S FULL NAME________________________________DOB____/____/______AGE ____ ___
☐ Male ☐ Female Grade__________ Reading Level _____ Years Months

PARENT'S FULL NAMES:

Mother____Father____

Step-Mother/NA_____________________________________Step-father/NA___________________________________

NAME/ADDRESS OF SCHOOL:

____
NAME STREET CITY STATE ZIP

TEACHER: _______________________________ SP.ED TEACHER:_____________________________

PRINCIPAL:___________________________

VISUAL HISTORY:

At what age did you first notice or suspect there was an eye turning? ______________________________________

Did the eye begin turning ☐ suddenly ☐ gradually?

Does the eye turn ☐ in ☐ out ☐ up ☐ down? (check all that apply)

Is the eye turn getting ☐ worse ☐ better, or is there ☐ no change?

Is it always the same eye that turns? ☐ Yes ☐ No

If yes, which eye? ☐ Right ☐ Left

Is the eye turn always present? ☐Yes ☐ No

If not, under what conditions is it present? (i.e. when tired, when ill, etc.) __________________________________

Do you notice if the eye turns more when your child is looking:

- at objects up close? ☐Yes ☐ No
- at objects in the distance? ☐Yes ☐ No
- to his/her left? ☐ Yes ☐ No
- to his/her right? ☐Yes ☐ No
- up? ☐Yes ☐ No
- down? ☐Yes ☐ No

Does one pupil ever appear to be larger than the other? Yes ☐ No ☐

Do you ever notice one or both eyes shaking rapidly? Yes ☐ No ☐

Does your child report any of the following?

	YES	NO	If yes, when?
Flashes of light	☐	☐	____________________
Floaters/spots	☐	☐	____________________
Blackouts	☐	☐	____________________
Itching	☐	☐	____________________
Burning	☐	☐	____________________
Redness	☐	☐	____________________
Eyes tired	☐	☐	____________________
Eyes hurt	☐	☐	____________________

Date of Completion of History___________

	YES	NO	If yes, when?
Blur: at near	☐	☐	______
at distance	☐	☐	______
after reading	☐	☐	After how long?______
Light sensitivity	☐	☐	______
Tearing/Itching	☐	☐	______
Double vision (1 object seen as 2)	☐	☐	______
Words move around on the page	☐	☐	______
Motion/car sickness	☐	☐	______

List any other complaints your child makes concerning his/her vision:______

______

Have you or anyone else ever noticed the following?

	YES	NO	If yes, when?
Eyes frequently reddened	☐	☐	______
Frequent eye rubbing	☐	☐	______
Frowning	☐	☐	______
Bothered by light	☐	☐	______
Frequent blinking	☐	☐	______
Closing or covering one eye	☐	☐	______
Difficulty seeing distant objects	☐	☐	______
Head close to paper when reading/writing	☐	☐	______
Avoids reading	☐	☐	______
Prefers to be read to	☐	☐	______
Tilts head when writing	☐	☐	______
Tilts head when reading	☐	☐	______
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	☐	☐	______
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	☐	☐	______
Does not support paper when writing	☐	☐	______
Awkward or immature pencil grips	☐	☐	______
Frequent erasures	☐	☐	______
Tires easily	☐	☐	______
Difficulty copying from chalkboard	☐	☐	______
Difficulty recognizing same word on on different page	☐	☐	______
Poor word attack skills	☐	☐	______
Difficulty with short term memory	☐	☐	______
Difficulty with long term memory	☐	☐	______
Remembers better what hears than sees	☐	☐	______

	YES	NO	If yes, when?
Oral responses better written responses	☐	☐	________________
Seems to know material but does poorly on tests	☐	☐	________________
Dislikes/avoids near tasks	☐	☐	________________
Short attention span/loses interest	☐	☐	________________
Poor/awkward large motor coordination	☐	☐	________________
Poor/awkward fine motor coordination	☐	☐	________________
Dislikes/avoids sports	☐	☐	________________
Difficulty catching/hitting a ball	☐	☐	________________

Child’s dominant hand: ☐ Right ☐ Left
Has guidance been given in which hand s/he uses? ☐ Yes ☐ No

Has your child complained to you about headaches? ☐ Yes ☐ No *If No, skip the following section.*
How frequent are the headache complaints?
☐Daily ☐1-2 per Week ☐3-4 per Week ☐Monthly ☐Infrequently
What is the location of the pain? ☐Temples ☐ Forehead ☐ Top of Head ☐Back of Head ☐ Neck
What is the nature of the pain? ☐ Dull ☐ Sharp ☐Constant ☐ Throbbing
How long does it usually last? ________ Does it curtail play? ☐ Yes ☐ No
What time of day does your child's headache usually occur? ☐Mornings ☐Afternoons ☐Evenings
How long has your child suffered from these headaches? ________________________________

PREVIOUS TREATMENTS

Has your child had a previous visual evaluation? ☐Yes ☐ No Age at first visit_______
Doctor’s Name: ____ Date of Last Visit: ____________________
Results and recommendations: ____
Were glasses, contact lenses, or other optical devices ever prescribed? ☐Yes ☐ No
If yes, ☐ Bifocal ☐ Single-vision ☐ Contact lenses ☐ Other Explain: ...______________________
Are they used? ☐Yes ☐ No
If yes, when are they worn? ____
If no, why not? ____
Does the eye turn less when the prescription is worn? ☐Yes ☐ No ☐ Unsure
Has there been any treatment using an eye patch? ☐Yes ☐ No
If yes, please describe when the patching was started, how the patching was done, including the age it started, the eye patched, the duration of treatment, and an estimate of the results: ______________________________
____
____

Have you ever been told that your child has amblyopia (“lazy eye”)? ☐Yes ☐ No
Has there been any surgical treatment? ☐Yes ☐ No
If yes, please describe the surgery, including the age surgery was performed, the number of operations, the eye operated on, and an estimate of the cosmetic and subjective results: ______________________________________
____
Were you satisfied with the results of surgery? ☐Yes ☐ No
Please explain: ____
Was the surgeon satisfied with the results of surgery? ☐Yes ☐ No
Please explain: ____
Are you here for a second opinion regarding surgery or further treatment? ☐Yes ☐ No
Has there been any visual therapy? ☐Yes ☐ No If yes, with Dr.______________________________

If yes, please describe the type of visual therapy, including its duration, the age at which it started, and an estimate of the results: ____

DEVELOPMENTAL HISTORY

Full term pregnancy? ☐Yes ☐ No If no, what was the length of the pregnancy?_______________

Were there any complications with pregnancy or at birth? ☐ Yes ☐ No If yes, please explain:

____

____

Child's birth weight _________ APGAR scores @ birth: _____ After 10 minutes_____

Were forceps used? ☐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

If yes, please explain: ____

____

Did your child crawl (stomach on floor)? ☐Yes ☐ No At what age? ________

Did your child creep (on all fours)? ☐ Yes ☐ No At what age? ________

At what age did your child walk? _________ Is/Was child active? ☐ Yes ☐ No

Speech: First words:____ At what age: ___________

Was early speech clear to others? ☐ Yes ☐ No Is speech clear now? ☐ Yes ☐ No

Are there communication concerns with: Expression? ☐ Yes ☐ No Understanding ? ☐ Yes ☐ No

Has your child been in Speech Therapy? ☐ Yes ☐ No If yes, when: ________________________________

MEDICAL HISTORY

Pediatrician's Name: _______________________________ Date of last examination:________________

For what reason? ____

Results and recommendations:____

Child's current state of health: ____

Medications currently used including vitamins and supplements: ____________________________________

____

For what conditions(s)?____

Is your child generally healthy? ☐ Yes ☐ No

Have there been any severe childhood illnesses, high fever, injury, or physical impairment?

If yes, please explain____

____

____

Has the child had any ear infections? ☐ Yes ☐ No If yes, please indicate how often and whether any treatment was received ____

____

Does the child have any allergies to food, medication or environmental allergies? ☐ Yes ☐ No If yes, please indicate to what and whether he/she is receiving any treatment: _________________________

____

Has your child ever had a neurological evaluation? ☐ Yes ☐ No If yes, please indicate *when* and the *results and recommendations:* ____

____

Does your child have any problems with

Blood	☐Yes ☐No	Heart	☐Yes ☐ No	Breathing	☐Yes ☐No
Skin	☐Yes ☐No	Hormones	☐Yes ☐No	Bladder	☐Yes ☐ No
Stomach/Intestines	☐Yes ☐No	Allergies	☐Yes ☐No	Ears/Nose/Mouth/Throat	☐Yes ☐No

If yes, to any of the previous problems, please describe____
____
____

NUTRITIONAL INFORMATION

Current Diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐
Does your child: Like sweets ☐ or crave sweets ☐
If yes, what types? ____
Are there any food allergies/sensitivities? Yes ☐ No ☐
If so, explain: ____
Is your child active? Yes ☐ No ☐ moderately ☐ extremely ☐

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)____
Does your child spend time with any other person, not in the home? ☐ Yes ☐ No
Please explain: ____
Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental or sibling illness)? ☐ Yes ☐ No If yes, at what age? ________
Does your child seem to have adjusted? ☐ Yes ☐ No ☐ Not applicable
Was counseling/therapy undertaken? ☐ Yes ☐ No ☐ Not applicable 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/other caretakers:____
Siblings:____
Classmates in school:____
Playmates at home:____
Did father or anyone in father's family have a learning/reading/spelling problem? ☐ Yes ☐ No
If yes, who?____
Did mother or anyone in 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 much TV does your child watch per day?____________
Viewing distance? ______________
Do you have DSL or cable internet connection in your home? ☐ Yes ☐ No
Does your child spend time using a computer or video games? ☐ Yes ☐ No
If yes, how much? __________ How often? ______________________ Viewing distance?_______________
What other activities occupy your child's leisure time?____
____
Are there any other activities your child would like to participate in, but doesn't? _______________________
Please explain: ____

FAMILY MEDICAL HISTORY

Are there any of your child's immediate family members (parent, sibling, grandparents, aunts/uncles) with any of the following?

Glaucoma?	☐ Yes ☐ No	If yes, who? ______________________
Cataracts?	☐ Yes ☐ No	If yes, who?______________________
Diabetes?	☐ Yes ☐ No	If yes, who?______________________
High Blood Pressure?	☐ Yes ☐ No	If yes, who?______________________
Thyroid Disease?	☐ Yes ☐ No	If yes, who? ______________________
Heart Disease?	☐ Yes ☐ No	If yes, who? ______________________

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 completed this form?

☐Mother ☐Father ☐Step-Mother ☐Step-Father ☐Adoptive Parents ☐Foster Parents ☐ Grandmother ☐Grandfather ☐Aunt ☐Uncle ☐Other Caretaker (please specify)______________________

______________________ Signature

______________________ Signature

EXPLANATION OF FEES

Dear Parents:

Headaches, poor academic performance, ADD/ADHD and eye strain are often caused by undiagnosed and untreated visual problems. You may have already come to the conclusion that glasses and educational intervention are not the answer to your child's problems. Dr. Vicky Vandervort has specialized in these areas for over 20 years. It is important to understand that the kind of care Dr. Vandervort provides goes beyond routine eye care. Her 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. It also describes our fees.

A thorough examination with dilation of the eyes 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. The fee is *typically* $155.00 to $320.00 depending on the level of examination needed. We do not participate in "vision/eyeglass" plans; therefore you may be responsible for a portion of your examination. If your optometrist has already dilated your eyes and you have them fax the information to us, you may be able to skip this exam and go directly to the next evaluation. Insurance Codes that are typically used are: [99244 and 92015] or [92004] depending upon your referral.

We then do testing 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 fees total $246.00. The insurance codes used are: 99214 and 92499.

If your child has no academic issues and is reading at or above grade level the following tests will likely not be recommended. It is used only in cases where learning-related visual problems are suspected based on the history you give Dr. Vandervort. This is a *complete* assessment of your child's brain's ability to understand and utilize his/her vision by the use of standardized, objective developmental testing with analysis of the results and consultation with Dr. Vandervort. The testing is done in two sessions and includes assessment of vision 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 fees for the testing and the extensive report and consultation total $610.00. 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. This occurs with other valuable and worthy services such as orthodontia (braces) and is not an indication of its 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 Services

HEARTLAND EYE CONSULTANTS

9900 Nicholas Street ○ Suite 250 ○ Omaha, NE 68114
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EXPLANATION OF FEES SIGNATURES

Patient Name: ________________________________

If patient is a minor, Parent Name: ________________________________

______I understand that I am responsible for the services provided according to my insurance company's Explanation of Benefits (EOB) including my co-pays and deductible.

______ ________________ **(please initial and date)**

_____I have no insurance and understand that prepayment of all of the fees will be required prior to each appointment. Financing options are available. If you have any questions, please do not hesitate to contact me.

______ _______________ **(please initial and date)**

___________________________ ___________ ___________________________ ___________

Patient Signature Date HEC Witness Date

___________________________ ___________

Parent Signature [if minor pt] Date

☐ Copy to Patient ☐ Copy to Patient Chart

HEARTLAND
EYE CONSULTANTS

9900 Nicholas Street ○ Suite 250 ○ Omaha, NE 68114
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CANCELLATION POLICY

Patient Name: ____________________________

If patient is a minor, Parent Name: ___________________________

In today's hectic world unplanned issues come up for all of us. We recognize this fact, but we respectfully request that if you need to cancel your appointment with us that you call at least **24 hours prior to your appointment.** With your prompt cancellation, we will be able to schedule another patient in need of an appointment.

If you cancel, reschedule, or miss your scheduled appointment **without** 24 hours notice, the first time will be excused. However, if you miss a second appointment you will be responsible to pay a **$50.00** fee. If a third appointment is missed, a **$100.00** fee will be charged. This fee is **not** covered by insurance carriers, Medicare or Medicaid and will be your responsibility to pay before rescheduling.

I understand the above Cancellation Policy implemented by Heartland Eye Consultants.

____________________________ ______________
Patient/Parent Signature Date

____________________________ ______________
HEC Employee Witness Date

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 with Dr. Vicky Vandervort at Heartland Eye Consultants (Tax ID # 34-2048045):

Comprehensive Consultation (CPT Code): 99244
Refraction (CPT Code): 92015
or
New Patient Exam (CPT Code): 92004

Visual Efficiency Exam (CPT Code): 99214
Electro-diagnostic Eye Movement Test (CPT Code): 92499

Visual Perceptual Testing 4 units (CPT Code): 96116
Parent Consultation (CPT Code): 99358
Progress Checks (CPT Code): 99214 (These will be administered every 6-8 weeks after therapy begins)

Optometric Visual Therapy, if prescribed by Dr. Vandervort, will be provided through our sister company Developmental Vision Associates, P.C. (DVA). ***DVA is a separate non- participating provider.*** This means that all fees will be paid by the patient and any reimbursement from the insurance company will be paid directly to the patient.

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

Orthoptics with medical direction (CPT Code): 92065

If you have any questions please don't hesitate to call our office at (402)-493-6500