

To Our Valued Patient:

Thank you for choosing Heartland Eye Consultants! We are looking forward to seeing you and your child for their appointment. Enclosed you will find a location map, brochure and several 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:
  - Teacher Observation
  - Permit for Release of Information
  - Children's Vision/Academic History
  - Explanation of Fees (Pink Sheet)
  - Pediatric Patient Demographic
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

Please give the **Teacher Observation Form** to your child's primary teacher. If you want more than one teacher to provide observations, please have them both use the *same* form, but use different colored ink.

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 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 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)

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**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: \_\_\_/\_\_\_/\_\_\_

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**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. I hereby authorize the holder of my medical and patient registration records to release any information needed 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:** \_\_\_\_\_

### CHILDREN'S VISION/ACADEMIC 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!

**First 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 \_\_\_\_\_ Step-father \_\_\_\_\_

NAME/ADDRESS OF SCHOOL:

TEACHER: \_\_\_\_\_ SP.ED TEACHER: \_\_\_\_\_

PRINCIPAL: \_\_\_\_\_

Is your child especially afraid of doctors?  Yes  No

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

**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

Date of your child's *most recent eye* examination? \_\_\_\_\_ performed by Dr. \_\_\_\_\_

Were glasses, contact lenses or optical devices recommended?  Yes  No

Was vision therapy recommended?  Yes  No Has your child ever had vision therapy?  Yes  No

PRESENT VISUAL CONDITION:

Why do you believe your child needs a visual evaluation? \_\_\_\_\_

How long has this problem/difficulty been observed? \_\_\_\_\_

Is there any evidence from the school, psychologist, or other tests that indicates a visual malfunction may be present?  Yes  No If Yes, what? \_\_\_\_\_

Does your child report any of the following?

	YES	NO	If yes, when?
Flashes of light	<input type="checkbox"/>	<input type="checkbox"/>	_____
Floater/spots	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blackouts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes tired	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes hurt	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blur: at near	<input type="checkbox"/>	<input type="checkbox"/>	_____
at distance	<input type="checkbox"/>	<input type="checkbox"/>	_____
after reading	<input type="checkbox"/>	<input type="checkbox"/>	After how long? _____

**DATE OF COMPLETION** \_\_\_\_\_

	YES	NO	If yes, when?
Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tearing/Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision (1 object seen as 2)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Words move around on the page	<input type="checkbox"/>	<input type="checkbox"/>	_____
Motion/car sickness	<input type="checkbox"/>	<input type="checkbox"/>	_____
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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent eye rubbing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frowning	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bothered by light	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent blinking	<input type="checkbox"/>	<input type="checkbox"/>	_____
Closing or covering one eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty seeing distant objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head close to paper when reading/writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Avoids reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prefers to be read to	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tilts head when writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tilts head when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Moves head when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Confuses letters or words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reverses letters or words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Confuses right and left	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skips, rereads or omits words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loses place while reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vocalizes when reading silently	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reads slowly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Uses finger as a marker	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor reading comprehension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Needs to re-read to understand	<input type="checkbox"/>	<input type="checkbox"/>	_____
Comprehension decreases over time	<input type="checkbox"/>	<input type="checkbox"/>	_____
Writes or prints poorly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Writes neatly but slowly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does not support paper when writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Awkward or immature pencil grips	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent erasures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tires easily	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty copying from chalkboard	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty recognizing same word on on different page	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor word attack skills	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with memory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Remembers better what hears than sees	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral responses better than written responses	<input type="checkbox"/>	<input type="checkbox"/>	_____

	YES	NO	If yes, when?
Seems to know material but does poorly on tests	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dislikes/avoids near tasks	<input type="checkbox"/>	<input type="checkbox"/>	_____
Short attention span/loses interest	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor large motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor fine motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with scissors/small hand tools	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dislikes/avoids sports	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty catching/hitting a ball	<input type="checkbox"/>	<input type="checkbox"/>	_____

Has your child complained to you about headaches (HAs)?  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 HA pain?  Temples     Forehead     Top of Head     Back of Head     Neck

What is the nature of the pain?  Dull     Sharp     Constant     Throbbing

How long does the HA usually last? \_\_\_\_\_ Does the HA curtail play?  Yes  No

What time of day does your child's HA usually occur?  Mornings     Afternoons     Evenings

How long has your child suffered from these HAs? \_\_\_\_\_

**DEVELOPMENTAL HISTORY**

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

Was the child born prematurely?  Yes  No If yes, what was the length of the pregnancy? \_\_\_\_\_

Child's birth weight \_\_\_\_\_ APGAR scores @ birth: \_\_\_\_\_ After 10 minutes \_\_\_\_\_

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? \_\_\_\_\_ 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 Reception?  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 condition(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, 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

### EDUCATIONAL HISTORY

Age at entrance to: Pre-school? \_\_\_\_\_ Kindergarten? \_\_\_\_\_ First grade? \_\_\_\_\_

Does your child like school?  Yes  No

Specifically describe any school difficulties: \_\_\_\_\_  
\_\_\_\_\_

Has your child ever repeated a grade?  Yes  No If yes, which grade? \_\_\_\_\_

Has your child changed schools often?  Yes  No If yes, when? \_\_\_\_\_

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

If yes, when? \_\_\_\_\_ From Whom? \_\_\_\_\_ How Long? \_\_\_\_\_

Results: \_\_\_\_\_  
\_\_\_\_\_

Does your child like to read?  Yes  No Voluntarily?  Yes  No

Does your child read for pleasure?  Yes  No What? \_\_\_\_\_

What is your child's attitude toward reading, school, his/her teachers, classmates? \_\_\_\_\_  
\_\_\_\_\_

Overall, school work, compared to classmates is:  above average  average  below average

Which subjects are:

Above average: \_\_\_\_\_

Average: \_\_\_\_\_

Below average: \_\_\_\_\_

Does your child need to spend a lot of time/effort to maintain this level of performance?  Yes  No

To what extent do you assist your child with homework? \_\_\_\_\_  
Do you believe your child is achieving up to his/her potential? \_\_\_\_\_  
Does the teacher believe your child is achieving up to his/her potential? \_\_\_\_\_  
At what age did a teacher first contact you about your child's difficulties? \_\_\_\_\_  
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.*  
Does your child attend school regularly?  Yes  No

**GENERAL BEHAVIOR**

Are there any behavior problems at school?  Yes  No If yes, what? \_\_\_\_\_  
\_\_\_\_\_  
Are there any behavior problems at home?  Yes  No If yes, what? \_\_\_\_\_  
\_\_\_\_\_  
What causes these problems? \_\_\_\_\_  
Child's reaction to fatigue?  irritable  wilts or sags  other \_\_\_\_\_  
Does your child say and/or do things impulsively?  Yes  No  
Is your child in *constant* motion?  Yes  No  
Can your child sit still for a long period doing an activity that s/he enjoys?  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) \_\_\_\_\_  
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?            | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, who? _____ |
| Cataracts?           | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, who? _____ |
| Diabetes?            | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, who? _____ |
| High Blood Pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, who? _____ |
| Thyroid Disease?     | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, who? _____ |
| Heart Disease?       | <input type="checkbox"/> Yes <input type="checkbox"/> 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

**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

**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.

## TEACHER'S OBSERVATIONS

*(Please complete in ink)*

Student's Name: \_\_\_\_\_

Grade \_\_\_\_\_ School \_\_\_\_\_

The child named above is receiving a Visual Evaluation at our office. In order to more clearly assess the impact of vision problems on classroom performance, we request your observations of this child.

Please respond to the items pertinent to this child and return the report to us as soon as possible. Your cooperation will be greatly appreciated. If multiple teachers respond, please use different colored pens on the same form. **Please do not duplicate the form.** Thank you.

Sincerely,

Dr. Vicky J. Vandervort

OBSERVABLE CLASSROOM BEHAVIORS POSSIBLY RELATED TO VISION PROBLEMS
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### APPEARANCE OF THIS STUDENT'S EYES

- \_\_\_\_\_ One eye turns in or out (at any time)
- \_\_\_\_\_ Reddened eyes or lids
- \_\_\_\_\_ Eyes tear excessively
- \_\_\_\_\_ Encrusted eyelids
- \_\_\_\_\_ Frequent sties on lids

### THIS STUDENT COMPLAINS TO YOU ABOUT:

- \_\_\_\_\_ Headaches in forehead or temples
- \_\_\_\_\_ Burning or itching after reading or desk work
- \_\_\_\_\_ Nausea or dizziness
- \_\_\_\_\_ Print blurs after reading a short time
- \_\_\_\_\_ Print "runs together" or jumps
- \_\_\_\_\_ Blurred when looks up from reading
- \_\_\_\_\_ Other Explain \_\_\_\_\_

## BEHAVIORAL SIGNS OF VISUAL PROBLEMS

### EYE MOVEMENT ABILITIES (Ocular Motility)

- \_\_\_\_\_ Head turns when reading across the page
- \_\_\_\_\_ Loses place often while reading
- \_\_\_\_\_ Needs finger or marker to keep place
- \_\_\_\_\_ Displays short attention span in reading or copying
- \_\_\_\_\_ Frequently omits words
- \_\_\_\_\_ Writes up or down hill on paper
- \_\_\_\_\_ Rereads or skips lines unknowingly
- \_\_\_\_\_ Orients drawings poorly on page

### EYE TEAMING ABILITIES (Binocularity)

- \_\_\_\_\_ Complains s/he sees double
- \_\_\_\_\_ Omits letters, numbers or phrases when reading
- \_\_\_\_\_ Misaligns digits in number columns
- \_\_\_\_\_ Reverts to "drawing with fingers" to determine similarities and differences
- \_\_\_\_\_ Squints, closes or covers one eye
- \_\_\_\_\_ Tilts head (extremely) while working at desk
- \_\_\_\_\_ Consistently shows gross postural deviations at all desk activities

### VISUAL MOTOR INTEGRATION

- \_\_\_\_\_ Must use kinesthetic input to assist in interpretation
- \_\_\_\_\_ Eyes not used to "steer" hand movements (extreme lack of orientation, placement of words or drawings on page)
- \_\_\_\_\_ Writes crookedly, cannot stay on ruled lines
- \_\_\_\_\_ Irregular spacing of letters within a word
- \_\_\_\_\_ Irregular spacing of words
- \_\_\_\_\_ Poor pencil grip
- \_\_\_\_\_ Uses other hand as "spacer" to control spacing and alignment on page
- \_\_\_\_\_ Misaligns both horizontal and vertical series of numbers
- \_\_\_\_\_ Uses his hand or finger to keep his place on the page
- \_\_\_\_\_ Repeatedly confuses left-right directions

### VISUAL PERCEPTUAL SKILLS (Non-motor)

- \_\_\_\_\_ Mistakes words with same or similar beginnings
- \_\_\_\_\_ Confuses similar endings of words
- \_\_\_\_\_ Does not know the same word in the same or next sentence
- \_\_\_\_\_ Confuses likenesses and minor differences
- \_\_\_\_\_ Reverses letters and/or words in writing and copying
- \_\_\_\_\_ Fails to visualize what is read either silently or orally
- \_\_\_\_\_ Whispers to self for reinforcement while reading silently

### REFRACTIVE STATUS

(Nearsightedness, Farsightedness, Focusing Problems)

- \_\_\_\_\_ Comprehension reduces as reading continues; loses interest too quickly
- \_\_\_\_\_ Mispronounces similar words as reading continues
- \_\_\_\_\_ Blinks excessively at desk tasks and/or reading only
- \_\_\_\_\_ Fatigues easily (blinks a lot after desk tasks)
- \_\_\_\_\_ Holds book too closely to face or is too close to desk surface
- \_\_\_\_\_ Avoids desk work
- \_\_\_\_\_ Complains of discomfort in tasks that demand visual interpretation
- \_\_\_\_\_ Closes or covers one eye when reading or doing desk work
- \_\_\_\_\_ Makes errors in copying from chalkboard (or reference book) to paper
- \_\_\_\_\_ Squints to see chalkboard, or requests to move nearer to chalkboard
- \_\_\_\_\_ Rubs eyes during or after short periods of visual activity

### CLASSROOM BEHAVIOR

Please mark ✓ for all appropriate items

- \_\_\_\_\_ Withdrawn, aggressive, other (list) \_\_\_\_\_ (Circle)
- \_\_\_\_\_ Behavioral problem(s) list \_\_\_\_\_
- \_\_\_\_\_ Difficulty sitting still
- \_\_\_\_\_ Difficulty maintaining interest in task at hand
- \_\_\_\_\_ Difficulty making friends

PLEASE COMMENT ON THE FOLLOWING QUESTIONS:

What is your major concern for this child academically?

Is s/he in the top, middle, or lower third of her/his class? (Circle)

Deficit in **reading** on standardized tests? Yes No Not yet tested (Circle) Year of test \_\_\_\_\_

Deficit in **math** on standardized tests? Yes No Not yet tested (Circle) Year of test \_\_\_\_\_

***What grade level equivalent is this child's Independent Reading Level?*** (Adequate comprehension and recall with no help) \_\_\_\_\_ (Please do not skip this important question.)

Is this child an average or above average speller? Yes No (circle one)

Once passed on spelling test, are most words retained and correctly spelled on subsequent creative writing projects? Yes No (circle one)

If *No*, does this child spell phonetically during creative writing assignments? YES NO  
(Circle)

Please check any other special areas of difficulty.

- |                           |                              |                        |
|---------------------------|------------------------------|------------------------|
| _____ Vocabulary          | _____ Memory                 | _____ Word recognition |
| _____ Reading <i>Rate</i> | _____ Comprehension          | _____ Interpretation   |
| _____ Attention           | _____ Oral Reading (fluency) | _____ Silent Reading   |

If s/he is reading below grade level, what do you believe are/were the major factors interfering with learning to read?

When the child was being taught to read in first and second grades, what percentage of the time was phonics used? \_\_\_\_\_% whole language system? \_\_\_\_\_%

What method of reading does this child utilize most of the time? Phonics Whole word

Has WISC-IV been given? *(Please circle)* YES NO

*If yes, please have the school psychologist send the results as soon as possible.*

Any other observations or comments?

If this child enters Optometric Vision Therapy, we will want to communicate with you about his/her progress. We know that you are busy and that your time is valuable. Email tends to be the most effective form of communication. If you are restricted from releasing your email address, how you would like us to communicate with you? Please provide phone number, best day of the week, and best time of day.

Classroom Teacher *(print name)* \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Alternate Contact Information: \_\_\_\_\_

Resource Teacher *(print name)* \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Alternate Contact Information: \_\_\_\_\_

SpEd Teacher *(print name)* \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Alternate Contact Information: \_\_\_\_\_

Thank you very much for your valued input.

### PERMIT FOR RELEASE OF INFORMATION

Please complete this form, in ink, so we may send the report to your child's school, optometrist or family physician and discuss his/her progress throughout the course of Optometric Vision Therapy. If no one is listed below, only you, the parent, will receive the final report. ***Please make sure that the fax numbers, e-mails, and addresses are filled out accurately to expedite delivery of the final report.*** Return this form to Dr. Vicky Vandervort with your completed questionnaires at your next visit.

I authorize the exchange of information and discussion of progress regarding \_\_\_\_\_ between Heartland Eye Consultants and Developmental Vision Associates and the people listed below: (Child's Name)

Mr./Mrs./Ms./Dr. _____ (Name)	_____ (Relationship to Your Child)
_____ (Phone)	_____ (Fax)
_____ (Street Address)	_____ (City, State, Zip)
_____ (E-mail)	<input type="checkbox"/> ACT

Mr./Mrs./Ms./Dr. _____ (Name)	_____ (Relationship to Your Child)
_____ (Phone)	_____ (Fax)
_____ (Street Address)	_____ (City, State, Zip)
_____ (E-mail)	<input type="checkbox"/> ACT

Mr./Mrs./Ms./Dr. _____ (Name)	_____ (Relationship to Your Child)
_____ (Phone)	_____ (Fax)
_____ (Street Address)	_____ (City, State, Zip)
_____ (E-mail)	<input type="checkbox"/> ACT

This statement of consent may be revoked at any time before disclosure of the information and expires, in any event, one year after it is signed.

Authorized by \_\_\_\_\_ Relationship \_\_\_\_\_  
(Signature)

Date \_\_\_\_\_