



Phone: (770) 904-0979

Visiontherapy4kids.com and MaxVisualPerformance.com

FORSYTH LOCATION:

2920 Ronald Reagan Blvd. #104
Cumming, GA 30041
Fax: 470-297-3854

GWINNETT LOCATION:

2055 Hamilton Creek Pkwy #120
Dacula, GA 30019
Fax: 470-655-7914

**WELCOME TO PEDIATRIC VISION DEVELOPMENT CENTER IN CONJUNCTION WITH
MAXIMUM VISUAL PERFORMANCE**

We look forward to meeting you at your appointment.

WHAT TO EXPECT AT YOUR APPOINTMENT:

Dr. Rouw and/or Dr. Shadeed will work directly with you during your evaluation for vision therapy and/or neuro-vision rehabilitation, which may include testing of the following visual skills: Eye Movement Control, Simultaneous Focus at Far, Sustaining Focus at Far, Simultaneous Focus at Near, Sustaining Focus at Near, Simultaneous Alignment at Far, Sustaining Alignment at Far, Simultaneous Alignment at Near, Sustaining Alignment at Near, Central Vision (Visual Acuity), Prescription for glasses, Peripheral Vision, Depth Awareness, Color Perception, Gross Visual-Motor, Fine Visual-Motor, Visual Perception, and Visual Integration.

FEES and PAYMENTS: The Pediatric Vision Development Center/Maximum Visual Performance is not a provider for insurance plans and does not submit claims to insurances. **ALL FEES FOR YOUR APPOINTMENT ARE DUE AT THE TIME OF THE SERVICE AND IS THE RESPONSIBILITY OF THE PATIENT/PARENT(S)/GUARDIAN(S).** Our office will be happy to write a Letter of Medical Necessity and provide invoices for your visits that may be helpful when you are submitting your claim in order for you to receive reimbursement from your insurance provider. It is against our office policy to receive payment from your insurance company.

CANCELLED OR MISSED APPOINTMENTS: Please understand that each appointment time is dedicated to you and is therefore not available to anyone else. We understand emergencies occur, please notify us as soon as possible if you are unable to keep your appointment. If you have not cancelled your appointment and do not show, you are making this appointment time unavailable for others.

There is a \$35.00 Fee for Not Showing for your appointment and/or Cancellations within 24 hours.

I understand that if I cancel or no-show for 2 consecutive appointments, I will be subject to removal from the schedule including all future appointments at the discretion of PVDC and MVP.

Signature _____ Date _____

Pediatric Vision Development Center Adult History Form

Date _____ Name _____ Gender: **M / F** Date of Birth _____ / _____ / _____

Mailing address _____
Street City State Zip Code

Contact Numbers: Hm _____ Cell _____ Email: _____

EYECARE DOCTOR: _____ Date of Exam _____ / _____ / _____
Name of Eyecare doctor Month Day Year

Location of Eye Exam _____
Name of Practice /Address Phone

MEDICAL DOCTOR: _____ Date of Exam _____ / _____ / _____
Name of Medical doctor Month Day Year

Location of Medical Exam _____
Name of Practice /Address Phone

How did you hear about us? Friend Internet Fairs/Conferences Optometrist Medical Dr OT/PT/SP Other _____

REFERRAL INFORMATION: The results of the testing will be sent to the referring professional.

Patient was referred by _____ Reason for Referral _____

Address _____ Phone _____

INFORMATION RELEASE: If you would like information sent to any addition person, please provide the following:

1. _____
Name Address City/ State Zip Phone Fax
Profession Type: Primary Care/Family Physician Rehabilitation therapist Optometrist Other _____
2. _____
Name Address City/ State Zip Phone Fax
Profession Type: Primary Care/Family Physician Rehabilitation therapist Optometrist Other _____

GENERAL HEALTH MEDICAL HISTORY

List ALL Allergies to Medications and/or Foods _____

List ALL Medications currently taking _____

List ALL major injuries, surgeries and/or hospitalization including concussions _____

OCULAR HISTORY

Current Prescription: None Glasses Contact lenses Prescription used for: Full time Near only Far only

OCULAR HEALTH HISTORY

List ALL major ocular injuries, surgeries _____

FAMILY HISTORY Have any of your relative- living or deceased had any of these conditions?

Ocular Disease/ Condition	Yes	No	Not Sure	Relationship to you
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Turn (Strabismus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy Eye (Amblyopia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Systemic Disease/ Condition	Yes	No	Not Sure	Relationship to you
Other _____				_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer / Type _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____				_____

Have you ever been exposed to or infected with: Hepatitis HIV/AIDS Syphilis Other _____ None

REVIEW OF SYSTEMS Do you currently, or have you ever had any problems in the following areas:

System	Yes	No	Not Sure	System	Yes	No	Not Sure
Skin (Integumentary)				Psychiatric			
Psoriasis				ADHD/ ADD			
Other:				Dyslexia			
Neurological				Anxiety			
Headache / Migraine				Other:			
Seizures				Ears, Nose, Mouth, Throat			
Autism Spectrum / Asperger				Seasonal Allergies/ Hay fever			
Sensory Disorder				Sinus Congestion			
Cerebral Palsy				Runny Nose			
Vomiting				Chronic Cough			
Clumsiness				Dry Throat/ Mouth			
Eyes				Respiratory			
Loss of Vision				Asthma			
Blurred Vision				Chronic Bronchitis			
Distorted Vision / Halos				Emphysema			
Double Vision				Vascular / Cardiovascular			
Dryness / Sandy Gritty Feeling				Diabetes			
Mucus Discharge				Heart Pain			
Redness				High Blood Pressure			
Itching / Burning				Vascular Disease			
Excess Tearing / Watering				Brain Injury / Stroke			
Tired Eyes				Other:			
Eye Pain/ Soreness				Gastrointestinal			
Sties / Chalazion				Diarrhea and/or constipation			
Flashes / Floaters in Vision				Bones/ Joint/ Muscles			
Endocrine				Arthritis			
Thyroid / Other Glands				Muscle and/or Joint Pain			
Allergic/ Immunologic				Lymphatic/ Hematological			
Fever, Weight Loss/ Gain				Anemia/Bleeding Problems			
Other:				Other:			

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MEDICAL RELEASE

I hereby understand and authorize Pediatric Vision Development Center obtain and/or exchange written and verbal information for the purpose of medical, visual, psychological, and/or educational evaluation. As vision therapy services at the Pediatric Vision Development Center can be a part of a multidisciplinary team, this authorization may include, but not limited to the following: Patient's eye care professional, referral professional, occupational therapist, physical therapist, speech therapist, behavioral therapist, school counselors/administrative, and pediatricians/medical physicians. The Pediatric Vision Development Center communicates with the patient/parent/guardian/ and the multidisciplinary team via: Fax, Email, Text, Postal mail, and/or Verbal communication. **Documents including but not limited to the following: initial evaluation reports, progress reports, letters of medical necessity, prescriptions, classroom accommodations may be emailed. _____ Initials**

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that my medical records include information regarding drug abuse/alcoholism/alcohol abuse/psychological/psychiatric conditions/ medical history including exposures or infections to diseases/ visual history and authorize the release of this information.

I do hereby release Pediatric Vision Development Center and its directors, agents, doctors, employees from any and all liabilities, responsibilities, damages, losses, and claims which might arise from the release of the information authorized above.

Print Name _____ Signature _____ Date _____

HIPAA AGREEMENT

I acknowledge that I understand the Notice of Privacy Practices provided by the Pediatric Vision Development Center and a copy has been shown/ provided to me upon request.

Print Name _____ Signature _____ Date _____