Location
820 E. Terra Cotta Ave, Suite 256
Crystal Lake, IL 60014
Mon-Thurs: 9AM-6PM
Sat: 9AM-12PM

Behavioral Vision
The Vision to Succeed
Carrie Sypherd, O.D.

Contact Information
www.behavioral-vision.com
behavioralvision@gmail.com
PHONE: 815-455-2800
FAX: 815-455-2801

Your information will be held in strict confidence in accordance with HIPAA.

EXAM DATE: _____/_____/_____
MONTH DAY YEAR

A. GENERAL INFORMATION

Child's full name: _____ Date of Birth: _____
Mother's full name: _____ Father's full name: _____
Mother's Occupation/Employer: _____
Father's Occupation/Employer: _____
Home address: _____
City/State/Zip: _____
Home Phone: _____ Cell Phone: _____
E-mail address: _____
Referred By: _____

B. PRIMARY MEDICAL INSURANCE INFORMATION

Insurance Company: _____ ID#_____ Group#_____
Primary on Insurance: _____Date of Birth: _____
Relationship to Patient: _____

C. MEDICAL HISTORY

Most recent medical examination: _____
Doctor's Name & Phone Number Exam Date_____
Is your child generally healthy? _____ Are there any chronic problems (asthma, hay fever, allergies)?
If so, please list: _____
_____
Medication(s) currently taking and for what condition?
_____
_____
_____
_____
Does child get car sick? _____ What gives relief? _____
List illnesses, bad falls, high fevers, hospitalizations, etc._____
Age Condition Severe/Mild Complications
_____
_____
_____
_____

Has a neurological evaluation been performed? Yes___ No___

By whom? _____

Doctors Name & Phone Number Exam Date

Results: _____

_____

Has a psychological evaluation been performed? Yes___ No ___

By whom? _____

Doctors Name & Phone Number Exam Date
Results: _____

_____

Full term pregnancy: Yes____ No ____ Normal birth: Yes ___ No____

Any complications before, during, or immediately following delivery? _____

_____

_____

Did your child creep? (stomach on floor) _____ Age: _____

Crawl? (stomach, off floor) _____ Age: _____ All fours: _____

If not, please describe: _____

At what age did your child walk? _____ Was child active? _____

First words at age _____ Was early speech clear to others? _____

Is it clear now? _____

Please list any medical or eye conditions that any family members may have such as high blood pressure, diabetes, cancer, thyroid disease, autoimmune disease, glaucoma, macular degeneration, other? Please list all conditions.

Condition Family relationship

_____

_____

_____

_____

_____

D. VISUAL HISTORY

Date of last eye exam: _____ Dr: _____

Address_____

Phone: _____ Reason for exam: _____

Glasses prescribed: _____

Contacts prescribed: _____

Diagnosis: _____

Medications prescribed: _____

Does your child have to take off glasses or contacts for any reason? _____

Do your child's eyes itch: _____ burn: _____ water: _____ other: _____

Has your child ever had an eye injury or operation? ____ Please describe: _____

_____

_____

Does your child have light sensitivity? _____

How much time does your child spend looking at a computer? _____

Does your child get headaches:Y/N Dull___ Pounding___ Sharp pain___ How often_____

What do you think causes the headaches? Near work _____ Reading _____ Computer Usage _____

Other _____ What does child do for relief? _____

E. SCHOOL

Child's handedness: Right____ Left____

School name: _____ grade level: _____

School phone: _____ Fax: _____

Teacher's name: _____ Principal's name: _____

Current special services: _____

Prior special services: _____

Age started kindergarten: _____ Does your child like school? _____

School work is (check one) above average_____ average _____ below average ____

Is your child working up to his/her potential?
Your feeling: _____

Teacher's feeling: _____

What subjects are easy for child? _____

What subjects are hard for child? _____

Does your child like to read? _____ Voluntarily? _____

What types of books does your child read? _____

Has your child repeated a grade and why? _____

Has your child changed schools often? _____ When? _____

How well developed is your child's spoken vocabulary? _____

Does your child have behavior problems at school? _____

Home?_____

_____

F. FAMILY

Siblings and their ages: _____

_____

G. HOBBIES AND OR INTERESTS

_____

_____

PLEASE GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:

_____

_____

H. REASON FOR VISIT

Please describe the reason for your visit: _____

_____

_____

_____

As part of the vision screening, we need to know how your child is doing in school.
Please check the areas that apply to your child:

- ❑ Average reader
- ❑ Slow/fast reader
- ❑ Doesn't enjoy reading
- ❑ Prefers to be read to
- ❑ Poor reading comprehension
- ❑ Poor writing skills
- ❑ Poor handwriting skills
- ❑ Has letter/number reversals
- ❑ Homework takes longer than it should
- ❑ Struggles in school
- ❑ Short attention span
- ❑ Inconsistent or poor sports performance
- ❑ Fine or gross motor skill difficulties
- ❑ Avoids tasks that involve reading
- ❑ Displays awkwardness and/or clumsiness
- ❑ Confuses similar looking words
- ❑ Misaligns numbers
- ❑ Writes up or down on a slant
- ❑ Complains of blurred vision
- ❑ Needs to move when reading
- ❑ Significant drop in grades in one year
- ❑ Told that he or she has a learning disability
- ❑ Has headaches, nausea, or dizziness when reading
- ❑ Honors curriculum
- ❑ Regular classroom
- ❑ Special Education
- ❑ Resource room
- ❑ Speech/Language
- ❑ Occupational Therapy
- ❑ Repeated grade _____
- ❑ Tutor _____
- ❑ Title I reading
- ❑ Fatigues, frustrated or stressed
- ❑ Omits, inserts or rereads letters and words
- ❑ Has difficulty copying from the chalkboard
- ❑ Nausea when doing close work
- ❑ Difficulty spelling
- ❑ Knocks over objects on a table

Other concerns:

_____
_____
_____
_____
_____
_____

OUR CANCELLATION POLICY

If you cancel your appointment less than 24 hours before it is scheduled to take place, you will be subject to a fee of $50, payable on your next visit. To avoid a cancellation fee, please provide cancellation notice at least 24 hours prior to your appointment.

_____ _____

PATIENT OR GUARDIAN SIGNATURE **DATE**

Patient Payment Responsibility

Most people have vision insurance and medical insurance. While they seem similar, they are quite different regarding the services they cover, and patients must understand those differences.

- Vision coverage (VSP, Eye Med, Davis Vision, etc.) is designed to determine a prescription for glasses and does not cover complex medical conditions. **We do not accept vision insurance.**

- Medical coverage (BCBS, Cigna, UHC, Aetna, etc.) if filed when a medical condition is present such as diabetes, cataracts, dry eyes, floaters, etc. In this case, co-pays and deductibles for your medical insurance will apply. **We are an out-of-network provider.**

- **Payment is due at the time of services.** We will submit any exam to your insurance company after payment is fulfilled, but it is the patient's responsibility to follow-up with their insurance company. Any coverage will be sent to you from your insurance company in the form of a reimbursement check as we are an out of network provider.

- **Medicare and Tricare Patients:** You will only be held responsible to pay for a copayment or a deductible that appears after we have been paid from your insurance provider.

- You will be held responsible for the cost of frames, lenses, or contact lenses purchased. We can provide you with invoice showing proof for payment to send along to your vision insurance.

Insurance carriers set these rules, and our office is required to follow them. We do our best to make sure you are aware of any out-of-pocket expenses associated with your visit.

If you have questions, please let us know.

I understand the paragraph above, and I authorize Behavioral Vision to file my insurance by the above guidelines. I am aware that I am responsible for any co-payments or deductibles set in accordance with my insurance provider. I am also responsible for any treatment or testing my insurance provider does not cover.

Patient Name: _____

Patient or Guardian Signature: _____ Date: _____

HIPAA FORM – SIGNATURE REQUIRED

NO AUTHORIZATION IS REQUIRED TO MAKE CERTAIN DISCLOSURES OF PROTECTED HEALTH INFORMATION

EFFECTIVE DATE _____

In order to comply with HIPAA's Privacy Rule, it is the policy of this office to obtain a signed patient authorization before making a use or disclosure of protected health information, except in those circumstances in which HIPAA does not require such an authorization. As stated in HIPAA, we will not obtain a signed patient authorization in the following circumstances:

1. Uses and disclosures for treatment, payment, or health care operations. This includes, among other activities:
   - Providing care to patients in our office.
   - Seeking assistance from consultants.
   - Making referrals of patients for follow-up care
   - Writing/sending and filling prescriptions for drugs and eyewear or contact lenses
   - Preparing and submitting claims and bills
   - Receiving/posting payments, and collection efforts
   - Managed care credentialing
   - Professional licensure and specialty board credentialing
   - Quality Assurance
   - Financial audits/management
   - Training of professional and non-professional staff, including students
   - Office management
   - Fraud and abuse prevention activities
   - Personnel activities
2. Notwithstanding the lack of need for a signed patient authorization, in order to comply with applicable state law, we will obtain permission from our patients before we disclose protected health information for the following activities:
   - Professional Visual Exams
   - Consultations
   - Therapy Services
   - Insurance letters
   - School reports
   - Teacher conferences
   - IEP's
   - Letters to other professionals requested by the families
3. Disclosures that are required by our state law, if we disclose only the precise protected health information required, and only to the recipient required. Disclosures to state, local or federal governmental public health authorities to prevent or control disease, injury, or disability. Disclosures to local, state, or federal governmental agencies to report suspected child abuse or neglect. Disclosures to individuals or organizations under the jurisdiction of the federal Food and Drug Administration ("FDA"), such as drug or medical device manufacturers, regarding the quality or safety of drugs or medical devices.
   Disclosures to local, state, or federal governmental agencies in order to report suspected abuse, neglect, or domestic violence regarding adults, providing that we:
   - Get an informal agreement from the patient unless:
     1. We are required by law to report our suspicions.
     2. We are permitted, but not required by law to disclose the protected health information, and we believe that a report is necessary to prevent harm to our patient or other potential victims.
   - We tell the patient that we are making this disclosure, unless:
     1. Telling the patient would put the patient at risk for serious harm or, someone else is acting on behalf of the patient and we think that this person is the abuser and that telling him or her would not be in the best interest of the patient.
4. Disclosures for health oversight audits, investigations, or disciplinary activities, provided that we only disclose to a federal, state or local governmental agency(or a private person or organization acting under contract with or grant of authority from the governmental agency)that is authorized by law to conduct oversight activities. Disclosures in response to a court order, provided that we disclose only the precise protected health information ordered, and only to the person ordered.
   Disclosures in response to a proper subpoena provided that:
   - We make sure that either we or the person seeking the subpoenaed information makes a reasonable effort to notify the patient in advance, and the patient has a chance to object to the court about the disclosure.
   - We make sure that either we or the person seeking the subpoenaed information makes a reasonable effort to have the court issue a protective order.
5. Disclosures to police or other law enforcement officers regarding a crime that we think happened at our office, if we reasonably believe that the protected health information is evidence of a crime. Uses of protected health information to market or advertise our own health care service. If at any time a proposed use or disclosure does not fit exactly into one of the exceptions to the need for an authorization described in paragraphs listed above, we will obtain a signed authorization before making the use or disclosure.

Notice of Privacy Practices

THIS NOTICE DESRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what tights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS:

The most common reason why we disclose your health information is for treatment, payment, or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you, testing or examining your eyes, prescribing glasses, contact lenses, or eye medications and faxing then to be filled; showing you low vision aids, referring you to another doctor or clinic for eye care or low vision aids or services, or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment, preparing and sending bills or claims, and collecting unpaid accounts (either ourselves or through a collection agency attorney). "Health care operations" mean those administrative and managerial functions that we must do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits, internal quality assurance; personnel decisions, participation in managed care plans, defense or legal matters; business planning and outside storage of records.
We routinely use your health information inside our office for these purposes without special permission. If we need to disclose your health information outside our office for these reasons, [we will] [we usually will not] ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all these situations will apply to us, some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities such as for the licensing of doctors; for audits by Medicare or Medicaid, or for investigation of
- possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide
- information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to
- organizations that handle organ or tissue donations;
- uses or disclosures for health related search;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful
- national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensations programs;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information

Unless you object, we will also share relevant information about your care with family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and /or leave you a message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form". The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization form, we cannot make use of disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using Email to your personal email address. We will accommodate these requests if they are reasonable.
- Ask to see or to get photocopies of your health information.
- Ask us to amend your health information if you think it is incorrect or incomplete.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want).
- Get additional paper copies of this notice of Privacy Practices upon request.

OUR NOTICE OF PRIVACY PRACTICES:

By Law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law.

COMPLAINTS:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION:

If you want more information about our privacy practices, call or visit the office contact person at the number shown at the beginning of this notice.

ACKNOWLEDEMENT OF RECEIPT OF HIPAA INFORMATION

I acknowledge that I have received a copy of Behavioral Vision's Notice of Privacy Practices

Patient Name: _____

Signature: _____ Date: _____