VIRGINIA NEURO-OPTOMETRY

3721 Westerre Parkway, Suite B
Richmond, VA 23233
Phone : (804) 387-2902
Fax : (804) 509-0543

Welcome!

Welcome to my practice at Virginia Neuro-Optometry, I look forward to meeting you at your first appointment. My goal is to provide diagnostic insight and rehabilitative/adaptive treatment options for patients who are struggling particularly with double vision, neurological visual field loss, as well as other visual complaints due to oculomotor dysfunction, brain injury and/or neurological disease. I provide comprehensive neuro-optometric examinations and rehabilitation services via in-office and telemedicine modalities. These services are beyond/complementary to primary eyecare services and I am happy to co-manage your care with your current primary eyecare doctor (optometrist and/or ophthalmologist). Further descriptions of my services can be found on my website: www.VirginiaNeuroOptometry.com.

Please complete and sign each enclosed document where appropriate prior to your examination. You can fax/mail forms back to our office or bring them with you to your examination. In this packet you will find the following forms:

Please don't hesitate to reach out to our office with any questions you have regarding my practice or the attached paperwork.

Sincerely,

Jacqueline M Theis

Dr Theis

Please note: I am not a neuro-ophthalmologist, and sometimes I need to co-manage your eyecare with other eyecare providers. If you are having sudden onset/emergent symptoms please call your primary eyecare provider (optometrist/ophthalmologist), primary care physician, or local emergency room.

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Notice of Privacy Practices

Virginia Neuro-Optometry
Located at
3721 Westerre Pkwy, Suite B Richmond, VA 23233
Phone: (804)-387-2902
Fax: (804)-509-0543

- Effective Date of this Notice: 05/28/2020
- Privacy official: Jacqueline Theis, drtheisod@virginianeurooptometry.com, Phone: (804)-387-2902
- Virginia Neuro-Optometry provides patients with access to their health information via the Practice Fusion Patient Portal

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Raise funds
- Please note, we do NOT
    - Maintain a hospital directory
    - Market or sell your personal information
    - Provide mental health care

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. We use the Practice Fusion Patient Portal, if you need assistance or more information please ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 15 days of your request in accordance with Virginia state laws. We may charge a reasonable, cost-based fee.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

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Potential ability to deny a request

We may deny your request to inspect and/or obtain a copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review

Right to Request an Amendment to Your Medical Record

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, your request must be made in writing and submitted to our office. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make that amendment;
- Is not part of the medical information kept by us;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

We will provide you with an explanation, in writing, describing why your request was denied within 60 days of receiving your request.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

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For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

We typically use or share your health information in the following ways.
Treat you: We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.
Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.
Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
Help with public health and safety issues: We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research: We can use or share your information for health research.
Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

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Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

General Release of Information
Virginia Neuro-Optometry may disclose any or all parts of my clinical records to any insurance company or companies, or in the case of Worker's Compensation claims, to my past or present employer(s), for purposes of satisfying charges billed by Virginia Neuro-Optometry. This authorization does not cover requests from other parties seeking information regarding my account.

_____
Patient/Guardian Name (printed)

_____ _____
Patient/Guardian Signature Date

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General Consent to Treatment and Right to Refuse Treatment

By signing below, I, (or my authorized representative on my behalf) authorize Jacqueline Theis, OD. and the staff at Virginia Neuro-Optometry and the Concussion Care Centre of Virginia, LTD to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

_____ _____
Patient/Guardian Signature Date

Telephone Consumer Protection Act (TCPA) Opt-In Consent form

Virginia Neuro-Optometry utilizes an automated patient notification system to quickly and efficiently notify patients of their upcoming appointment. You must "opt" in to consent to receive automated communications on your mobile device. You can revoke this consent at any time. Please take a moment to fill out this consent form to receive these messages.
I give Virginia Neuro-Optometry and Practice Fusion permission to contact me via
___ wireless telephone for automated phone calls
___ SMS text messages
___ email.

By signing, I certify that I am the owner of the wireless phone and/or email designated as the primary contact on the patient information form.

_____ _____
Patient/Guardian Signature Date

Consent to Communicate via Email – Email is not HIPAA Compliant

Virginia Neuro-Optometry will do its best to encrypt all patient information. Information stored on our computers is encrypted. However, most popular email services (ex. Hotmail ®, Gmail ®, Yahoo ®) do not utilize encrypted email. When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the internet. In addition, once the email is received by you, someone may be able to access your email account and read it. I acknowledge that not all email is HIPAA compliant and I voluntarily give my permission to Virginia Neuro-Optometry at Concussion Care Centre of Virginia LTD to communicate with me or my child via e-mail. This communication could include but is not limited to: appointment reminders, requested superbills, requested letters/summary reports, and receipts

YES I give permission to communicate using this address _____
NO I do NOT want any communication to occur via e-mail

_____ _____
Patient/Guardian Signature Date

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Telemedicine Consent Form

Telemedicine services may be offered as sole or partial treatment.

Telemedicine services involve the use of audio, live video (like Skype, Zoom, Doxy.me Etc.,), or other electronic communications to interact with you for the purpose of providing medical care, and/or follow-up services on an individual basis. A potential risk of telemedicine is that your specific concerns, or unforeseen technical issues, may still necessitate a face-to-face session with a healthcare provider as part of your ongoing treatment.

Additionally, in **RARE circumstances** security protocols could fail causing a breach of patient privacy. All laws concerning patient access to medical records and copies of medical records apply to telemedicine. You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consultation without affecting your right to future care or treatment. The alternative to telemedicine is a face-to-face visit with a clinician.

I do hereby consent to allow my provider to record any or all parts of my telehealth session(s). This includes video and/or audio recording of any conversations, consultations and virtual treatments/office visits

I understand that the recordings of my telehealth sessions and virtual communications are for the sole use of my treatment and medical documentation, and will not be used in any marketing or advertising; nor will they be used as patient testimonials without my express written consent.

I understand that I have a right to request copies of such recordings and have the right to revoke this authorization in writing at any time during the course of my treatment.

I understand that this authorization will remain in place in perpetuity, or until such time as I revoke the authorization in writing.

Patient/Guardian Name (printed)	Patient/Guardian Signature	Date

Permission to Disclose Private Health Information (PHI) for Family members and/or Friends

By signing this document, I given permission to the person(s) listed in the table documented below to receive private health information or other authorization, as listed in the comments section. Furthermore, I understand that once disclosed, my PHI may be re-disclosed by the person(s) authorized, meaning it may no longer be protected by law. I understand this form is legally binding and that I may revoke my authorization at any time by submitting a written request to change, add, or terminate such permission.

Date of Permission	Name of Individual	Comments/Permissions	Initials	Date Permission Revoked	Initials	Telephone Number

Patient/Guardian Name (printed)	Patient/Guardian Signature	Date

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Specific Authorization for Release/Exchange of Health Information

Patient Name: _____ **Date of Birth:** _____ **SSN** _____

I, _____ request and authorize Virginia Neuro-Optometry to release health record information for: _____ (patient name or self)
to: _____ (Name of person receiving information).

The purpose of this release is for

- ☐ Receiving care at Virginia Neuro-Optometry
- ☐ Discharge Planning
- ☐ Other (please state): _____

Please specify the health information you authorize to be released:
Type(s) of health information: _____
Date(s) of treatment/visits: _____

Would you like the records to be:

- ☐ Faxed
- ☐ Mailed
- ☐ In Person Pick-Up

☐ **Please send the records to:**
Name: _____
Address: _____
_____
Phone: _____
Fax: _____

OR

☐ **Send records to:**
Virginia Neuro-Optometry
3721 Westerre Parkway, Suite B
Richmond, VA 23233
Phone : (804) 387-2902
Fax : (804) 509-0543

NOTICE

Virginia Neuro-Optometry and other health organizations are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS

- This Authorization to release health information is voluntary. Treatment, payment, and elegibility for benefits may not be conditioned on signing this Authorization except for the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.
- This Authorization can be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to clinic Privacy Officer, at Virginia Neuro-Optometry, 3721 Westerre Parkway, Suite B, Richmond, VA 23233. The revocation will take effect when Virginia Neuro-Optometry receives it, except that others or we have already relied on it.
- You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires: _____ (insert applicable date or event). If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

_____ _____
Print Name Date

_____ _____
Signature (Patient, Parent, Guardian) Relationship to Patient (Parent, Guardian, or Patient Representative)

For Internal Use: Information release: Initials_____ Date:_____
Copy of authorization to patient: Initials_____/Authorization Revoked Date_____

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General Authorization for Release of Information

To Prior and Current Treating Physicians and/or Facilities, Schools, Employers, Pharmacies, Attorneys and/or Courts, and Mental Health Professions of the Below Named Patient.

I hereby authorize any of the above to furnish all records, reports, imaging studies, progress notes, and/or other information they request relating to any examination, history, background and/or treatment pertaining to me, either past or present to Virginia Neuro-Optometry.

Name: _____ DOB_____ SSN _____
Printed Last, First

Address: _____
Number, Street Name

_____
City, State, Zip

Patient Signature:_____ Today's Date: _____

If Applicable

Parent/Guardian Name: _____
Printed Last, First

Parent/Guardian Signature:_____ Today's Date:_____

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Medicare/Medicaid/Tricare Opt-Out Notice to ALL Patients

This memo is to serve as notice that Jacqueline Theis, OD, has opted out of all federally-funded insurance programs and therefore does not participate with Medicare, Medicaid or Tricare. Because of the opt-out, Virginia Neuro-Optometry cannot file any claims with Medicare and neither can any of our patients. As the beneficiary of any of the above-named programs, patients are expected to pay in full at the time of service. The charge for initial comprehensive evaluation is $399, and follow up charges range from $35-175 (see fee schedule for details). Additional services will be charged separately and costs will be discussed with each patient prior to the services being rendered.

Section 4507 of the 1997 Balanced Budget Act allows a physician or practitioner to enter a private contract with a Medicare beneficiary. Signatures from the provider, a witness and the patient/beneficiary or their legal representative are required below.

- I, Jacqueline Theis, OD (provider's name) have not been excluded from Medicare under sections 1128, 1156 or 1892 of the Social Security Act, 1689015901 (provider's NPI number).
- I (the Medicare beneficiary) or my legal representative accept full responsibility for payment of charges for all services furnished by Jacqueline Theis, OD (provider's name).
- I (the Medicare beneficiary) or my legal representative understand that Medicare limits do not apply to what Jacqueline Theis, OD (provider's name) may charge for items or services furnished.
- I (the Medicare beneficiary) or my legal representative agree not to submit a claim to Medicare or to ask Jacqueline Theis, OD (provider's name) to submit a claim to Medicare.
- I (the Medicare beneficiary) or my legal representative understand that Medicare payment will not be made for any items or services furnished by Jacqueline Theis, OD (provider's name) that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.
- I (the Medicare beneficiary) or my legal representative enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- The expected or known effective date and expected or known expiration date of the opt-out period is 08/21/2020 (effective date) and 08/21/2022 (expiration date).
- I (the Medicare beneficiary) or my legal representative understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare. This contract cannot be entered into by me, (the Medicare beneficiary), or by my legal representative during a time when I, (the Medicare beneficiary), require emergency care services or urgent care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 3044.28 of the Medicare Carriers Manual)
- I (the Medicare beneficiary) or my legal representative will receive or have received a copy (a photocopy is permissible) of this contract, before items or services are furnished to me under the terms of this contract.
- I Jacqueline Theis, OD (provider's name) will retain the original contract (original signatures of both parties required) for the duration of the opt-out period.
- I Jacqueline Theis, OD ((provider's name) will supply CMS with a copy of this contract upon request. I Jacqueline Theis, OD (provider's name) understand that the current private contract remains in effect for two years. If I again opt-out of Medicare, I will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

Provider's NPI: 1689015901
Provider's Signature: _____ Date: _____
Patient's Signature: _____ Date: _____
Patient's Legal Representative Signature: _____ Date: _____
Witness: _____ Date: _____
Contact Name:_____ _____ Phone #: _____ Email: _____

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Virginia Neuro-Optometry Services and Fees

Neuro-Optometric Evaluation (New-Patient, In-office) $399

A comprehensive neuro-optometric examination evaluates the aspects of vision from the eye to the brain that can be affected by damage to the central and peripheral nervous system. These diagnostic tests may include and/or evaluate

- How well you see – visual acuity (clarity), contrast sensitivity, color vision, peripheral vision, light sensitivity, pupil reaction, refractive prescription, eye health
    - Ocular health and glasses exam can be co-managed in some cases with your primary eye care provider (optometrist or ophthalmologist), please contact our office staff for details
- How well your eyes work together as a team – eye alignment, eye movements (sensorimotor/oculomotor examination)
- How the eyes move while your head is moving and/or stationary (vestibular-oculomotor examination)
- How well the brain interprets what you see – visual processing (speed, recognition, orientation)

The goal of the initial neuro-optometric evaluation is to determine what is the cause of the visual complaint and work together with the patient and family to create the best individualized treatment plan

Telemedicine Neuro-Optometric Evaluation (New-Patient) $275

Some patients with post-concussion vision problems may be able to have an intake examination and started on treatment through telemedicine. Due to the limitations of telemedicine, certain tests may not be able to be performed (ocular health, glasses refraction), and therefore patients may need to co-manage these services with a local eye care provider in-person if they are unable to come into the office.

Telemedicine/Telephone/In-Office Neuro-Optometric Rehabilitation Follow Up Appointments

Virginia Neuro-Optometry offers a revolutionary and cost-effective model for home-based orthoptics vision therapy. Patients will be prescribed home exercises that they perform 5-20min/day at home, and then follow up with the doctor either via telemedicine or in-office, to adjust the exercises and monitor progress. The exam fee is due at the time of each visit and will be based on doctor-time spent with the patient.

<5 min	**Free**
5-10 min	**$35**
10-15 min	**$75**
15-25 min	**$125**
25-35 min	**$175**

Vision Rehabilitation Equipment

Some (but not all) of the vision exercises used in neuro-optometric rehabilitation may require equipment. As you progress through your rehab, you will be able to purchase the equipment through our clinic. If you need it to be shipped, we ask that you cover all shipping expenses.

Additional Procedures The following procedures may be needed in addition to your examination

- Optic Nerve/Retinal Scan Interpretation– $25
- Automated Visual Field Testing/Interpretation - $25-65
- Fundus Photography - $25-45
- Extended Visual Processing Examination $150-250

_____
Patient/Guardian Initial

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Additional Fees

Cancellation Policy and No-Show Fee

Since our goal is to be able to see patients as soon as possible, our appointment slots are in high demand. Whenever a patient fails to show for an appointment, another patient is deprived of early treatment. Therefore, when an appointment is cancelled at the last minute, it is difficult for our staff to quickly reach another patient to fill the appointment slot. If you are unable to keep your appointment, please give us 24 hour's notice. No-show visits (missed appointments without 24 hours notifications) will be charged a fee of $35.

Bounced Check

If you prefer to pay with a personal check and your check bounces, you will be charged an additional fee of $25. Additionally, you will then be asked to pay with a different form of payment (cash or credit card).

Paperwork/Letters

If you need a formal letter/paperwork to be filled out that requires extensive time outside of your patient visit, you may be billed a fee of $49. We recommend you bring all paperwork with you to your exam, as often times many forms can be filled out for you at the time of service.

Payment Options

- We are a fee-for-service practice and we do not participate with any commercial insurance plans in order to provide our patients with the best possible care.
    - We can try to coordinate some of your services (ocular health exam and refraction) with your primary care eye doctor to reduce some of the costs – please call our office for more information
    - We can provide you with a superbill that you can submit to your insurance at the end of the examination, but please note that reimbursement may not be guaranteed (see statement of financial responsibility below)
    - Please note you cannot submit to medicare for reimbursement (see medicare waiver page 10)
- Payment is due at the time of service, by cash, check or debit/credit card (Visa, Mastercard, Discover), unless you are a worker's compensation client (see below).
- All telemedicine visits must be paid at the time of service through the online portal using a credit or debit card.

Worker's Compensation

We accept all forms of Worker's Compensation insurance. Please contact your case manager and inquire about having an examination with Dr. Theis. Your case manager will need to contact the Concussion Care Centre of Virginia, LTD at 804-270-5484 and they will send out a contract for their authorization.

Statement of Financial Responsibility

I acknowledge that I am legally responsible for all charges in connection with the care and treatment provided by representatives of Virginia Neuro-Optometry. I assign and authorize payments to Virginia Neuro-Optometry. I understand this business is a fee-for-service entity and does not accept private/commercial/medicare/medicaid insurance. I understand that I can submit for reimbursement to my insurance on my own (except in the case of Medicare – see attached medicare notice), but that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions coverage limits, lack of authorization or medical necessity.

I understand that I am responsible for the above fees at the time of service including in-office and telemedicine visits. I understand and have read the above fee schedule.

_____ _____

Patient/Guardian Signature Date

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Patient History Form

First Name_____ Last Name _____
Date of Birth _____/_____/_____ Birth Sex _____ Gender _____
Mailing Address_____
City _____ State _____ Zip Code_____
Home Phone _____ Cell Phone _____ Fax_____
Email address_____
Preferred method of contact_____
Occupation/Employer_____
If applicable,
Parent/Guardian Name(s)_____
Parent/Guardian Phone_____
Parent/Guardian Email _____
Emergency Contact Information
Contact Name_____
Contact Phone _____
Contact Email _____
Relation _____

Who Referred you to this clinic? _____
Relationship to referral source:_____-
If a referred by healthcare provider:
Specialty_____
Date last seen _____
Office Address_____
City _____ ___State _____ Zip Code_____
Office Phone _____ Fax_____

What were you referred for?
- ☐ Post-concussion neuro-optometric examination and rehabilitation
- ☐ Double vision examination
- ☐ Post-stroke Functional Visual Field Examination
- ☐ Visual processing examination
- ☐ Self-referral/other:_____

Is this under Workman's Compensation Insurance?
- ☐ Yes
- ☐ No

Primary Care Physician_____
Date last seen _____
Office Address_____
City _____ ___State _____ Zip Code_____
Office Phone _____ Fax_____

VIRGINIA NEURO-OPTOMETRY

3721 Westerre Parkway, Suite B
Richmond, VA 23233
Phone : (804) 387-2902
Fax : (804) 509-0543

Medications

Have you recently started a new medication or stopped taking a medication? If yes, please describe below. If no, please write "n/a"

Nutritional Supplements (Vitamins, Minerals, Herbs, Homeopathy) include name/brand, dose, frequency, start date, reason for use

Allergies (food, medications, environmental):

Personal Medical History: Are you currently under the care of a healthcare professional for a medical/ health condition? If yes, please describe condition below and name/contact information of treating physician if not your primary care physician If no, please write "n/a"

Do you have or had in the past any of the following conditions?

- ☐ Autoimmune/Inflammatory conditions (Rheumatoid arthritis, Lupus, Graves disease)
- ☐ Cancer (of any type)
- ☐ Cardiovascular (High blood pressure, high cholesterol, heart attack, bradycardia)
- ☐ Genital and Urinary (Gout, Herpes)
- ☐ Gastrointestinal (Chrohn's disease, inflammatory bowel disease, Gout)
- ☐ Hematological (bleeding problems, Hepatitis, HIV, IV drug use)
- ☐ Metabolic (Diabetes/Pre-diabetes, hypoglycemia)
- ☐ Musculoskeletal (arthritis, fibromyalgia)
- ☐ Respiratory (Asthma, pneumonia, sleep apnea, chronic obstructive pulmonary disease)
- ☐ Skin (Eczema, rash)

If you answered yes to any of the boxes above, please describe the condition and name of physician who is managing your condition (if not your primary care physician listed above)

_____

_____

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Any history of surgery and/or hospitalizations? If yes, please describe type of surgery/reason for hospitalization, date(s), surgeon, location of surgery If no, please write "n/a"

_____
_____
_____

Do you have or had in the past any of the following NEUROLOGICAL/PSYCHIATRIC/MOOD conditions?

- ☐ Anxiety
- ☐ ADD/ADHD
- ☐ Alzheimer's Disease
- ☐ Bipolar Disorder
- ☐ Brain Surgery
- ☐ Brain Tumor
- ☐ Concussion
- ☐ Depression
- ☐ Headaches
- ☐ Migraines
- ☐ Moderate/Severe Traumatic Brain Injury
- ☐ Multiple Sclerosis
- ☐ Multiple System Atrophy
- ☐ Myasthenia Gravis
- ☐ Parkinson's Disease
- ☐ Progressive Supranuclear Palsy
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Stroke
- ☐ Other

COVID-19 Screening for In-Office use

We want everyone to stay happy and healthy. Due to COVID-19, we have taken extra precautions to ensure your safety and that of our staff. Please note that we ask

- Face masks worn by all patients over 2 years of age. Please bring your own face mask.
- Maximum one family member per in-office visit
- Office forms need to be filled out prior to your appointment
- Our office staff will be taking your temperature upon entering the front door. If you have a temperature above 100 degrees we will cancel your appointment and send you home.

Please cancel your appointment if you have had any of the following symptoms within the last two weeks: fever, cough, chills, sore throat, shortness of breath, recent loss of taste/smell, diagnosed with or known exposure to COVID-19.

Who is your primary eye care Optometrist/Ophthalmologist?
Name_____
Date last seen _____
Office Address_____
City _____ ___State _____ Zip Code_____
Office Phone _____ Fax_____

Please list any FAMILY members who have or had medical or EYE issues and their relationship to you (Ex: Father - Cataract, glaucoma). If no issues to report, please write "n/a

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What are your main visual concerns that are bringing you in?

Please briefly describe your injury/accident/diagnose (date, time, loss of consciousness, symptoms at time of injury, etc)

Have you had neuroimaging?

- ☐ Yes
- ☐ No

If Yes – when and what kind?_____

Are you experiencing any of the following non-visual PHYSICAL symptoms?

- ☐ Appetite change
- ☐ Brain Fog
- ☐ Chills
- ☐ Cognitive changes– difficulties with memory/concentration
- ☐ Disorientation
- ☐ Fatigue
- ☐ Fever
- ☐ General fatigue
- ☐ Headache
- ☐ Hearing loss
- ☐ Jaw pain while chewing
- ☐ Loss of Balance
- ☐ Loss of Memory
- ☐ Loss of Speech (words/difficulty with speech/finding your words)
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Nausea
- ☐ Neck pain/whiplash injury
- ☐ Neck stiffness
- ☐ Pain
- ☐ Shortness of breath/Difficulties breathing
- ☐ Sleep problems (sleeping too much, not enough, waking up multiple times during the night, can't fall asleep)
- ☐ Tingling in arms, legs, fingers or toes
- ☐ Weakness/numbness/loss of function in the face/arms/legs
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Vertigo(the world is moving around you)
- ☐ Vomiting

Personal Ocular History: Please list any ongoing eye conditions you have currently or have had in the past

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Are you experiencing any of the following EYE or VISION symptom(s)?

- ☐ Anxiety in visually crowded areas (restaurants, grocery stores, hallways)
- ☐ Blurred Vision when head is stable
- ☐ Blurred Vision when head is moving
- ☐ Carsickness
- ☐ Difficulty with reading (unable to read for long periods of time, slow to read, poor reading comprehension, skipping words, words move on the page, loses place while reading)
- ☐ Difficulty with electronics/screens/scrolling
- ☐ Difficulty with glare
- ☐ Difficulty with depth perception (lack of confidence walking/missing steps/stumbling)
- ☐ Difficulty with visual search tasks
- ☐ Dizziness with visual tasks
- ☐ Double vision
- ☐ Dry eye symptoms (foreign body sensation, tearing, light sensitive towards end of the day or morning, intermittent blurry vision, itching)
- ☐ Fatigue
- ☐ Flashes of light
- ☐ Floaters in vision
- ☐ Headaches provoked with reading/near vision tasks (phone, computer)
- ☐ Light sensitivity to fluorescent lights
- ☐ Light sensitivity to outdoor sunlight
- ☐ Light sensitivity to electronic devices
- ☐ Light sensitivity to indoor lighting
- ☐ Light sensitivity worse in the morning
- ☐ Light sensitivity worse in the evening
- ☐ Pain in or around the eyes
- ☐ Pain on the side of your eyes or forehead
- ☐ Restricted visual field of view
- ☐ Vision Loss - Loss of side vision or part of vision

Of all of the things that you have had difficulty doing, what is the top 1-3 things that are the MOST important for you to return to/regain?

Are there any other healthcare providers in your care team that you would like us to contact/keep informed? (Please list name/specialty/contact information below)