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:

- ☐ Notice of Privacy Practices – HIPAA statement, as required by law — Pages 2-4
- ☐ Consents to Treatment and Right to Refuse Treatment — Page 5
- ☐ Consent to Communicate via Telephone, Email, and Telemedicine — Page 5
- ☐ Permission to Disclose Information - to any party (family/friends) listed — Page 6
- ☐ General Authorization for Release of Information — Page 6
    - Allows our practice to request records from present and past providers
    - If you would like your records sent to a particular office/person at a later time not listed in your intake paperwork, you can ask our office for a release form at any time
- ☐ Medicare/Medicaid/Tricare Opt-Out Notice/Waiver — Page 7
- ☐ Description of Services and Fee Schedule — Page 8-9
- ☐ Statement of Financial Responsibility — Page 10
- ☐ Patient History Forms — Page 11-17

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

Sincerely,

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.

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

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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.

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.

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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

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. By signing below, I authorize Virginia Neuro-Optometry to release my health information: (1) to any requesting health care provider for my further care or treatment or for that provider's payment or health care operation purposes; (2) to any person or entity which may be responsible for billing/collection of claims for medical services; (3) to any person or entity which is, or may be liable for all or part of Virginia Neuro-Optometry's charges, including but not limited to, credit card companies; (4) to any governments agency or other organization responsible for oversight of the practice; (5) for Virginia Neuro-Optometry's normal health care operations. I authorize the practice to communicate with me through text or email, even if not encrypted, and to allow the individuals listed above to access such information through any medium including over the internet, even though the emails may not be encrypted, and through Virginia Neuro-Optometry's electronic medical record system.

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

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

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 if applicable Date

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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

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 if applicable: _____ Date: _____
Witness: _____ Date: _____
Contact Name:_____ _____ Phone #: _____ Email: _____

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Virginia Neuro-Optometry
Description of Services and Fees

Neuro-Optometric Evaluation (CPT 92004/99204 + 92060) $399

A problem-focused 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 exams take about 1-1.5 hours. The diagnostic tests may include but are not limited to:

- How well you see – evaluation of visual acuity (clarity), contrast sensitivity, color vision, peripheral vision, light sensitivity, pupil reaction and dynamics, eye health
    - *Ocular health and glasses(refraction) can be co-managed in some cases with your primary eye care provider (optometrist or ophthalmologist) for a "collegial referral discount" so you can use your vision/medical insurance with your routine eye care provider. Please contact our office staff for details on how to coordinate care. You will need a recent DILATED eye examination with your primary eye care provider prior to seeing Dr. Theis, and these records need to be sent to our office PRIOR to your examination. Please note a spectacle refraction is a separate procedure (see below)*
- How well your eyes work together as a team – eye alignment, eye movements (oculomotor examination)
- How the eyes move while the head is moving (vestibular/cervical-oculomotor examination/screening)

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.

Visual Processing/Perception Evaluation (CPT 96116 +96121) $299

Virginia Neuro-Optometry offers advanced visual processing evaluations upon request for patients with developmental concerns (pediatrics) and/or neurological disorders including brain injury and stroke to help identify how the brain interprets what the eyes see. We evaluate visual processing skills including but not limited to visual response time, visual attention, visual memory, visual motor integration, visual spatial planning, and left hemi-neglect syndrome. These examinations are helpful to help guide patients in their post-stroke/brain injury rehabilitation recovery, make modifications to the environment (home/workplace/educational setting) to improve the visual efficiency and safety of patients, and make educational recommendations based on visual processing skill strengths and weaknesses. The average visual processing exam will take 1.5 hours of in-office testing. Dr Theis will then evaluate the results, write a comprehensive report, and discuss the results with a follow up visit with the patient and any caretakers involved. Please note this exam can only be done after a neuro-optometric evaluation has been performed to ensure accuracy of visual processing testing.

Double Vision/Strabismus Evaluation (CPT 92060+) $114

Some patients have double vision due to congenital/developmental or age-related deficits and do not require the aforementioned extensive neuro-optometric evaluation and have been referred by their primary eye-care provider. For these patients we offer this service at procedure cost. Treatment options for double vision including vision therapy and/or prism will be in addition (see costs below) depending upon the examination findings.

Neurological Visual Field Loss Evaluation (CPT 92060+96116+92081) $350

When a patient has visual field loss due to a neurological injury like a brain injury, cerebral hemorrhage or stroke, they may lose a part of their peripheral vision (left side/right side) due to damage of the visual pathway in the brain. While these patients may see clearly and have normal eye health exams, they may still struggle with their vision – bumping into things, knocking things over, fatigue with reading, etc. This evaluation looks specifically at how much of the visual field is remaining and how we can maximize the patient's use of that vision using prismatic visual field expansion or oculomotor visual field re-training. This also includes visual processing screening to differentiate if the patient has solely visual field loss or visual inattention (hemineglect) as well.

_____
Patient/Guardian Initials

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Additional/Isolated Procedures

Every patient is different and not every patient needs every procedure performed – especially if they are being co-managed with another eye doctor. To be able to flexibly accommodate for this factor and make our services affordable, the following procedures may be needed in addition to your neuro-optometric examination and/or in place of the comprehensive neuro-optometric examination depending on the case and co-management with your primary eye care doctor.

- CPT 92015: Glasses Refraction $44
- CPT 92012/99213/92002/99202 - Dilated ocular health exam $75
- CPT 92015-TG Prismatic Glasses Refraction $76
- CPT 930265 Orthoptics Vision Therapy in-office visit $125
- CPT 92133-26/92134-26 Optic Nerve/Retinal Scan Interpretation $25
- CPT 92081/92082/92083 Automated Visual Field Testing/Interpretation $25-65
- CPT 92250 Fundus Photography Testing/Interpretation $25-45

Neuro-Optometric Rehabilitation Follow Up and Vision Therapy 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 every 1-3 weeks depending on the patients progress. The fees will be based on time so the patient and provider can work out a cost-effective therapy program for them.

<5 min	Free
5-10 min	$35
10-15 min	$75
15-25 min	$125
>25 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 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.

_____

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Payment Options

- 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).
- 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 and the amount of time that they need to be properly evaluated.
  - 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 with the aforementioned CPT codes that you can submit to your insurance at the end of the examination. You can call your insurance company ahead of time to see what may be covered under your out-of-network reimbursement policy. Please note that reimbursement may not be guaranteed and is dependent upon your individual insurance plane (see statement of financial responsibility below).
  - Please note you cannot submit to medicare for reimbursement (see medicare waiver) as we are not a medicare provider
- 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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Fax : (804) 509-0543

New Patient Demographic Information

_____ _____ _____
Patient Name (Please print) Date of Birth (mm/dd/yyyy) SSN

_____ _____
Parent/Guardian Name (Please print) Relation to patient

Mailing Address_____
City _____ State _____ Zip Code_____
Physical Address: *if different from mailing address* _____
City _____ State _____ Zip Code_____

I wish to be contacted in the following manner (fill in all that apply)	May we leave messages here with personal medical information? (Y/N)

Cell Phone: _____ _____
Home Phone : _____ _____
Work Phone: _____ _____
Fax : _____ _____
Email : _____ _____

Is this under worker's compensation (Yes/No)? _____ If Yes, who is your case manager (name, phone number, email)?_____

Emergency Contacts (must be listed on disclosure form)				
Name	**Relationship**	**Home Phone**	**Cell Phone**	**Work Phone**

Healthcare Team				
Provider Type	**Provider Name**	**Phone Number**	**Fax/Email**	**Office Location**
Primary Care Physician (PCP)				
Referring Physician *(if not PCP)*				
Please list any other physician's providers you want us to contact: Example Optometrist, Physical Therapist, Psychologist, Neurologist, etc)				

Preferred Pharmacy Name:_____
Phone Number:_____
Address: _____

VIRGINIA NEURO-OPTOMETRY

3721 Westerre Parkway, Suite B
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Patient History/Medical Information

Who Referred you to Virginia Neuro-Optometry clinic?_____

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:_____

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

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

□ Wears Glasses
□ Wears Contacts

Family Ocular History: Please list any FAMILY members who have or had medical or EYE issues and their relationship to you (Ex: Father - Cataract, glaucoma).

Medical Problems/Diagnoses *(Current and Past):* Please list any medical/health conditions (Ex: diabetes, thyroid, hypertension). Attach additional sheets if needed. Please list name of treating physician if the condition is managed by someone other than your primary care physician.

Surgical History: Please list any surgeries and/or hospitalizations over night, along with dates. Attach additional sheets if needed.

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Allergies:

Medication/Food/Environment	Allergic Reaction	Severity

Current Medications, Including Supplements:

Name of Medication/ Vitamin/Supplement/Herb	Dose (how much do you take)	Frequency (how many times do you take it per day)	Is it helpful/reason for taking?

Have you recently started or stopped taking a new medication (If Yes, which one)?

_____

Family Health History: Please provide health information about your family members, including grandparents, siblings, and children

Relation	Health Problem(s)
Father	
Mother	
Siblings	
Children	
Grandparents	
Other	

Social History/Health Habits:

Relationship Status: _____ Occupation: _____

Smoking/tobacco: ☐ Never ☐ Former (quit date_____) ☐ Current _____ per day, for _____ years)

Alcohol Use (check one): ☐ No ☐ Yes (_____ drinks per _____)

Who else lives in your household? _____

Do you have resources for emotional support? _____

How often do you exercise, currently and prior to your injury? How long? What types of exercise?

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General	□ Weight loss □ Loss of Appetite □ General Fatigue	□ Weight Gain □ Increased appetite	□ Fevers or Chills □ Pain
Ear, Nose, Throat	□ Voice Hoarseness □ Hearing loss □ Tinnitus	□ Neck swelling/mass □ Jaw pain while chewing	□ Loss of smell □ Loss of taste
Cardiovascular	□ Chest pain □ High blood pressure	□ Palpitations	□ Leg Swelling
Respiratory	□ Cough □ Shortness of breath	□ Wheezing □ Sleep Apnea	□ Breathlessness
Gastrointestinal	□ Nausea □ Vomiting	□ Abdominal pain	□ Diarrhea
Genitourinary	□ Frequent urination	□ Urgency to urinate	□ Painful urination
Musculoskeletal	□ Noted change in strength/ability to exercise	□ Neck pain □ Neck stiffness/ restriction in mobility	□ Joint pain/stiffness
Skin/Hair	□ Increased body hair □ Rash	□ Loss of body hair	□ Loss of scalp hair
Neurologic	□ Headache □ Tingling in arms/legs/fingers/toes □ Weakness/numbness loss of function in face/arms/legs	□ Migraine □ Dizziness □ Vertigo (world is moving around you)	□ Loss of Balance □ Loss of Consciousness
Cognitive	□ Confusion □ Difficulty with memory □ Difficulty with concentration	□ Disorientation □ Difficulty with speech (finding or loss of words)	□ Cognitive fatigue □ Brain fog
Mood	□ Anxiety □ ADD/ADHD/inattention	□ Irritability	□ Depression □ Mania
Endocrine	□ Cold sensitivity □ Milk production (other than breastfeeding)	□ Heat sensitivity □ Irregular menstrual period	□ Decreased libido

Sleep History: How is your sleep and sleep quality? (e.g., hours/night, sleeping too much or not enough; waking up frequently throughout the night; sleep position?) _____
_____

Previous and Current Rehabilitation Therapy:

□ Physical Therapy _____
□ Occupational Therapy _____
□ Speech and Language Therapy _____
□ Neuro-psychology _____
□ Psychological Consult/Counseling _____
□ Vision Therapy _____

Co-Management: 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 (fax) below:

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Neuro-Optometric History Form

Brain Injury/Neuro History: Please briefly describe your injury/accident/diagnosis (date, time, loss of consciousness, symptoms at time of injury, etc) and/or reason for coming to our practice:

Did you have neuroimaging performed, and if so when and what type (e.g., CT or MRI of brain):
_____

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

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?
1) _____
2) _____
3) _____

In regards to symptoms when reading or doing close/computer work:

	Never	Rarely	Sometimes	Frequently	Always
□ Eyes feel tired					
□ Eyes feel uncomfortable					
□ Eyes feel sore					
□ Eyes hurt					
□ Feel a “pulling” feeling around the eyes					
□ Get headaches					
□ Feel sleepy/tired					
□ Lose concentration					
□ Have trouble remembering what you read					
□ Have double vision					
□ Words move, jump, swim, or float on the page					
□ Read slowly					
□ Words blur or come in and out of focus					
□ Lose your place					
□ Have to re-read the same line of words					

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Your Vision Symptoms: Please mark (x) each symptom you have experienced in the last 4 weeks or since your injury.

Visual Clarity	□ Blurry vision at distance with head stable □ Blurry vision at distance with head moving □ Blurry vision at near □ Blurry vision fluctuates throughout the day □ Reduced vision at night
Double Vision	□ Double vision is horizontal – two images side by side □ Double vision is vertical – two images up and down □ Double vision is at distance □ Double vision is at near
Visual Tasks Provoke Physical Symptoms of	□ Headaches □ Dizziness □ Nausea □ Brain fog – confusion, disorientation □ Fatigue □ Eye pain □ Eye strain
Light Sensitivity to	□ Normal indoor lighting □ Fluorescent indoor lighting □ Outdoor sunlight □ Electronics/screens □ Flashing/strobing/flickering lights
Dry Eye Symptoms	□ Vision/light sensitivity worse in the morning □ Vision/light sensitivity worse in the afternoon □ Eyes sting/burn/feel dry □ Eyes are red □ Eyes water
Depth Perception	□ Clumsiness/misjudge where objects really are in space □ Lack of confidence walking, missing steps, stumbling □ Poor Handwriting (spacing, size, legibility)
Peripheral vision	□ Side vision is distorted/objects move or change position □ Missing piece/part of peripheral vision □ Difficulty with visual motion □ Carsickness □ Flashes of light □ Floaters
Visual Processing	□ Anxiety in visually crowded areas (restaurants, grocery stores) □ Difficulty with visual search tasks (ex: can't find the milk in the fridge) □ Difficulty concentrating on a task □ Poor ability to organize work □ Confusion following a series of verbal instructions □ Confusion following a series of written instructions □ Confusion with directional orientation/maps/planning in space □ Difficulty with memory

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Vision Quality of Life with Time Survey (VisQuaL-T)

Please fill out if any of the following activities below give you symptoms, and if so, how long it takes before they begin. Symptoms include headache, dizziness, eye strain, double vision, floating words, blurry vision, inability to pay attention, easily distracted, or sleepy/drowsy. If you do not perform a specific activity and it is not applicable to you, select N/A. If you never experience any of the symptom listed above for the specific activity, select 60+ min. *Note: If you select more than four N/A's, fill out one Optional Additional Activity for each N/A's above four. For example, if you selected 6 N/A's, fill out two of the Optional Additional Activities. In the Optional Activities, fill out an activity you perform regularly that is more applicable to you.*

Activities Important to You	0 – 15 min	15 – 30 min	30 – 45 min	60+ min	N/A
Read for pleasure?					
Study for a test / examination?					
Complete homework?					
Complete work in an office setting? (i.e. reading / writing / typing reports)					
Be in crowded locations? (i.e. malls, train station, airports, meetings, busy walkways, etc.)					
Tolerate habitual lighting in a classroom or workplace?					
Use a smartphone / tablet?					
Play a computer / console video game?					
Use a computer or laptop for general purposes? (i.e. email, Facebook, etc.)					
Watch a show / movie on a screen larger than 9"? (iPad Pro or larger)					
Additional Activity 1: _____					
Additional Activity 2:_____					