Center for Better Learning

Better Vision. Brighter Future.

CHILDREN'S VISION QUESTIONNAIRE

Please fill out this questionnaire carefully and return it to our office before your child's appointment.

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ **Gender:** ☐Male ☐Female

Street Address: _____

Address **City** **State** **Zip Code**

RESPONSIBLE PERSON(S) INFORMATION

Mother

Name: _____ **Email Address:** _____

Home Phone: (_____) _____ - _____ **Cell Phone:** (_____) _____ - _____

Street Address: ☐Same Address as Patient

_____

Address **City** **State** **Zip Code**

Father

Name: _____ **Email Address:** _____

Home Phone: (_____) _____ - _____ **Cell Phone:** (_____) _____ - _____

Street Address: ☐Same Address as Patient

_____

Address **City** **State** **Zip Code**

PRESENT SITUATION

Were you referred to our office? ☐Yes ☐No

If yes, by whom? _____

Chief Complaint/Reason for the Visit: _____

At which age did you notice the problem? _____

Has the problem become: ☐Better ☐Worse ☐Stayed the Same

Has there been any previous treatment? ☐Yes ☐No

If yes, please describe: _____

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SCHOOL HISTORY

Is your child homeschooled? ☐Yes ☐No

Name of School: _____ **Grade:** _____

Has your child repeated a grade? ☐Yes ☐No If yes, which grade? _____

Does your child like school? ☐Yes ☐No

Does your child like his/her teacher? ☐Yes ☐No

Is your child's school work: ☐Above Average ☐Average ☐Below Average

Which classes are at or above grade level?

☐Language Arts ☐Math ☐Music ☐PE ☐Science ☐Social Studies ☐None

Which classes are below grade level?

☐Language Arts ☐Math ☐Music ☐PE ☐Science ☐Social Studies ☐None

Does your child like to read? ☐Yes ☐No

Does your child prefer to be read to rather than reading on his/her own? ☐Yes ☐No

Do you feel your child is working up to his/her full potential? ☐Yes ☐No

Does your child attend any special classes? ☐Yes ☐No

If yes, please describe: _____

Does your child have an IEP? ☐Yes ☐No

If yes, what accommodations are recommended? _____

Has your child been diagnosed with: ☐Dyslexia ☐ADD/ADHD ☐Behavioral Issues

ADDITIONAL TESTING HISTORY

Educational: ☐Yes ☐No **If yes, what were the results?** Click or tap here to enter text.

Hearing: ☐Yes ☐No **If yes, what were the results?** Click or tap here to enter text.

Neurological: ☐Yes ☐No **If yes, what were the results?** Click or tap here to enter text.

Psychological: ☐Yes ☐No **If yes, what were the results?** Click or tap here to enter text.

Speech: ☐Yes ☐No **If yes, what were the results?** Click or tap here to enter text.

OT/PT: ☐Yes ☐No **If yes, what were the results?** Click or tap here to enter text.

MEDICAL HISTORY

Primary Care Doctor: _____

Street Address: _____

Address **City** **State** **Zip Code**

Last Visit Date: _____

Reason for Visit: _____

Is your child taking any medications? ☐Yes ☐No

If yes, which medications and what dosage? _____

_____

DEVELOPMENTAL HISTORY

Was your child adopted? ☐Yes ☐No

Was your child: ☐Full Term ☐Premature (under 37 weeks)

Were there complications at birth?

☐Toxemia ☐Pre-eclampsia ☐Trauma ☐Alcohol Use ☐Drug Use ☐Severe Illness ☐C-section

If yes to any, please explain: _____

Did your child crawl? ☐Yes ☐No

If yes, at what age? _____ For how long?: _____ (days/months/years)

Did your child walk: ☐Early (before 11 months) ☐On Time ☐Late (after 14 months)

Did your child move any other way other than crawl or walk? ☐Yes ☐No

If yes, please describe: _____

Are your child's gross motor skills: ☐Normal ☐Below Normal

Are your child's fine motor skills: ☐Normal ☐Below Normal

Which hand is your child's dominant hand? ☐Right ☐Left

At what rate did your child's speech develop? ☐Normal (before 18 months)
☐Delayed (after 18 months)

HEAD INJURY HISTORY

Has your child had any kind of head injury? ☐Yes ☐No **Was he/she hospitalized?** ☐Yes ☐No

If yes to head injury, please describe (when, how did it happen, etc.):

_____

VISUAL HISTORY

Date of last eye examination: _____ **Doctor's Name:** _____

Prescribed: ☐Glasses ☐Contacts ☐Optical Devices

Prescribed for: ☐Full-time wear ☐Distance wear only ☐Near wear only

Have the following vision problems been diagnosed?:

Amblyopia (lazy eye): ☐Yes ☐No

If yes, was there any treatment for the Amblyopia?: ☐Yes ☐No

If yes, describe treatment: _____

Strabismus (eye turn): ☐Yes ☐No

If yes, at what age was the eye turn first noticed? _____

Did the eye turn start: ☐Suddenly ☐Gradually Which eye turns?: ☐Left ☐Right ☐Both

Which direction does the eye turn? (check all that apply): ☐In ☐Out ☐Up ☐Down

When does the eye turn? (check all that apply):

☐Always ☐Rarely ☐Beginning of the Day ☐End of the Day ☐When Tired

Has your child had any treatment for the strabismus? ☐Yes ☐No

If yes, describe treatment: _____

ACTIVITIES

(Check the sports or athletic activities your child actively participates in)

☐ Archery	☐ Baseball	☐ Basketball	☐ Cheerleading
☐ Equestrian	☐ Football	☐ Golf	☐ Gymnastics
☐ Ice Hockey	☐ Lacrosse	☐ Martial Arts	☐ Skating
☐ Skiing	☐ Soccer	☐ Softball	☐ Swimming
☐ Tennis	☐ Track and Field	☐ Volleyball	☐ Wrestling

Please list any hobbies or special interests:

_____

Which adjectives best describe your child's personality?

☐ Adaptable	☐ Calm	☐ Careful	☐ Compassionate
☐ Competitive	☐ Courageous	☐ Courteous	☐ Decisive
☐ Dedicated	☐ Driven	☐ Enthusiastic	☐ Helpful
☐ Honest	☐ Industrious	☐ Loyal	☐ Open-minded
☐ Patient	☐ Perfectionist	☐ Responsible	☐ Self-reliant
☐ Self-starter	☐ Stable		

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VISUAL SYMPTOMS

College of Optometrists in Vision Development (COVD) Symptom List	Never	Seldom	Occasionally	Frequently	Always
Blurred close vision	☐	☐	☐	☐	☐
Double vision	☐	☐	☐	☐	☐
Headaches with near work	☐	☐	☐	☐	☐
Words run together while reading	☐	☐	☐	☐	☐
Burning, itchy, watery eyes	☐	☐	☐	☐	☐
Falls asleep while reading	☐	☐	☐	☐	☐
Sees worse at the end of the day	☐	☐	☐	☐	☐
Skips/repeats lines while reading	☐	☐	☐	☐	☐
Dizzy/nauseated by near work	☐	☐	☐	☐	☐
Head tilt/one eye closed to read	☐	☐	☐	☐	☐
Difficulty copying from the board	☐	☐	☐	☐	☐
Avoids near work/reading	☐	☐	☐	☐	☐
Omits small words when reading	☐	☐	☐	☐	☐
Writes uphill/downhill	☐	☐	☐	☐	☐
Misaligns digits/columns of numbers	☐	☐	☐	☐	☐
Poor reading comprehension	☐	☐	☐	☐	☐
Poor/inconsistent in sports	☐	☐	☐	☐	☐
Holds reading too close	☐	☐	☐	☐	☐
Trouble keeping attention reading	☐	☐	☐	☐	☐
Difficulty completing work on time	☐	☐	☐	☐	☐
Says “I can’t” before trying	☐	☐	☐	☐	☐
Avoids sports/games	☐	☐	☐	☐	☐
Poor hand/eye coordination	☐	☐	☐	☐	☐
Poor handwriting	☐	☐	☐	☐	☐
Does not judge distance accurately	☐	☐	☐	☐	☐
Clumsy, knocks things over	☐	☐	☐	☐	☐
Poor time use/management	☐	☐	☐	☐	☐
Does not make change well	☐	☐	☐	☐	☐
Loses things/belongings	☐	☐	☐	☐	☐
Car or motion sickness	☐	☐	☐	☐	☐
Forgetfulness/poor memory	☐	☐	☐	☐	☐

Notice of Privacy Practices

Effective January 1, 2013

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. If you have any questions, please contact our office. We are required by law to: Maintain the privacy of your protected health information, give you this notice of our duties and privacy practices regarding health information about you, and follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:

Described as follows are the ways we may use and disclose health information that identifies you (Health Information, or PHI). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to us and stating that you wish to revoke permission you previously gave us.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment. However, if you pay for your services yourself (e.g. out-of-pocket and without any third party contribution or billing), we will not disclose Health Information to a health plan if you instruct us to not do so.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. Subject to the exception above if you pay for your care yourself, we also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operations.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you. We will not, however, send you communications about health-related or non health-related products or services that are subsidized by a third party without your authorization.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through an approval process. Even without approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising and Marketing. Health Information may be used for fundraising communications, but you have the right to opt-out of receiving such communications. Except for the exceptions detailed above, uses and disclosures of Health Information for marketing purposes, as well as disclosures that constitute a sale of Health Information, require your authorization if we receive any financial remuneration from a third party in exchange for making the communication, and we must advise you that we are receiving remuneration.

Other Uses. Other uses and disclosures of Health Information not contained in this Notice may be made only with your authorization.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by federal, state or local law**.**

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our office.

Right to Amend. If you feel that Health Information we have 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 our office. To request an amendment, you must make your request, in writing, to our office.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our office.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our office. ***We are not required to agree to all such requests***. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing, to our office. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.centerforbetterlearning.com. To obtain a paper copy of this notice, please request it in writing.

Right to Electronic Records. You have the right to receive a copy of your electronic health records in electronic form. Right to Breach Notification. You have the right to be notified if there is a Breach of privacy such that your Health Information is disclosed or used improperly or in an unsecured way.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

I acknowledge having been provided this Notice.

Signed: _____

Center for Better Learning

Better Vision. Brighter Future.

Out-of-Network Advanced Patient Notice Form

You are seeking service(s) from Murray Eye Associates, LLC. Christina Murray O.D. is a non-preferred or an out-of-network provider for your insurance.

You have the right to receive services at a participating facility or by a participating physician or provider in order to obtain full benefits under your health coverage. If you have questions or would like to locate an in-network physician, provider or facility to provide the service or procedure, please contact your customer service provider on the back of your insurance card.

To be completed by the patient or patient's legal guardian:

By placing my signature on this waiver form below, I acknowledge the following:

1. I am aware that Christina Murray O.D. does not participate with my insurance company.
2. I understand that I may be responsible for additional costs for all services provided by Christina Murray O.D. as specified in my benefit contract.
3. I was given an opportunity to contact my insurance company before obtaining these services by Christina Murray O.D. to confirm my benefits for these non-network services and to obtain names of participating facilities and/or participating providers that can provide the recommended service or procedure.
4. I am voluntarily choosing on behalf of myself or my child/legal guardian to obtain the service or procedure from the non-participating facility and/or physician.

_____ _____

Signature of Patient, Parent (if under age 18) or Legal Guardian Date

_____

Printed Name

Center for Better Learning

4171 W Hillsboro Blvd STE 13

Coconut Creek, FL 33073

Center for Better Learning

Better Vision. Brighter Future.

REQUEST TO RELEASE PROTECTED HEALTH INFORMATION

Center for Better Learning
Christina Murray O.D.
4171 W Hillsboro Blvd STE 13
Coconut Creek FL, 33073
Ph/Fax: (561)462-1245

By signing this form, I authorize Center for Better Learning to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

RE: Patient Name: _____

Date of Birth: _____ Phone Number: _____

TO: _____
Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____
Street Address

_____
City, State and Zip Code

Phone Number: _____ Fax Number: _____

☐ I understand that my records may contain information regarding a diagnosis or treatment. I authorize the use or disclosure of the above specified information to be retrieved for medical purposes only.

☐ I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reached the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.

Signature of Patient: _____ **Date:** _____

If the patient is a minor or unable to sign, please complete the following:

Signature of Authorized Representative: _____ Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient: ☐ Parent ☐ Legal Guardian ☐ Court Order