ViewFinder
Low Vision Resource Center

(480)924-8755
www.viewfinderlowvision.com

Prepare For Your Low Vision Consultation

LOCATION:

1. **Mesa:** 1830 S Alma School Rd #131, 85210
2. **Phoenix:** 1234 E Northern Ave, Foundation for Blind Children, 85020
3. **Tucson:** 3532 E Grant Rd, Tucson, AZ 85716
4. **Prescott Valley:** 2517 North Great Western Drive, Rummel Eye Care, 86314

WHAT TO BRING:

1. This new patient paperwork packet, filled out and signed.
2. Please bring your insurance cards to **ALL** appointments.
3. Bring your current eyeglasses, magnifiers, and other vision aids.
4. Bring a copy of your most recent medical eye exam report.

HOW LONG WILL IT BE:

A Low Vision Consultation will take between **two to four hours** to complete, longer if you also need a medical eye exam with dilation. **Please arrange your transportation plans accordingly.**

Please call at least 24 hours in advance for cancellations. Cancelled appointments on the same day or missed appointments may receive a "no show" charge of $60.00.

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Patient Registration Information

Name: _____

Date of Birth: _____/_____/_____ Male _____ Female _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Email address: _____

Medical Insurance:_____ ID#_____

No Vision Plans Accepted

Primary Care Physician: _____

Phone: _____ Fax:_____

Date of Last Exam: _____/_____/_____

Primary Eye Doctor: _____

Phone: _____ Fax:_____

Date of Last Exam: _____/_____/_____

Retinal, Glaucoma, Cornea, Neuro-Ophthalmology Specialists:

1. _____

Phone: _____ Fax:_____

Date of Last Exam: _____/_____/_____

2. _____

Phone: _____ Fax:_____

Date of Last Exam: _____/_____/_____

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Ocular History: Please check all that apply to you.

____ **Age-Related Macular Degeneration:** ___ Right Eye _____ Left Eye

Ocular injections? How Often? _____

____ **Glaucoma:** ___ Right Eye _____ Left Eye

Surgery or Laser procedures? _____

____ **Diabetic Retinopathy**: ___ Right Eye _____ Left Eye

Ocular injections? How Often? _____

Surgery of Laser procedures? _____

Most Recent Hemaglobin A1C Score: _____ %

____ **Cataracts:** ___ Right Eye _____ Left Eye

Surgery or laser procedures? _____

____ **Retinal Detachment:** ___ Right Eye _____ Left Eye

Surgery? _____

____ **Inherited Retinal Dystrophy:**

Genetic Type:_____

Family History:_____

____ **Optic Nerve Disease**: ___ Right Eye _____ Left Eye

___ Hypoplasia _____ Atrophy ___ Ischemia

____ **Strabismus (Crossed Eye):** ___ Right Eye _____ Left Eye

Surgery? _____

____ **Amblyopia (Lazy Eye):** ___ Right Eye _____ Left Eye

____ **Dry Eye:** ___ Right Eye _____ Left Eye

Current Treatments:_____

Additional Notes:

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Medical History: Please check all that apply to you.

GENERAL CONSITUTION:
___ Appetite Changes
___ Weight Changes
___ Fatigue
___ Cancer
Type: _____

CARDIOVASCULAR:
__ High Blood Pressure
___ High Cholesterol
___ Chest Pain
___ Heart Attack
___ Cardiac Arrest
___ Irregular Heartbeat
___ Pacemaker
___ Artificial Valve

EARS/NOSE/THROAT:
___ Sinus Problems
___ Seasonal Allergies
___ Hearing Loss

LUNGS:
___ Asthma
___ Emphysema
___ Shortness of breath
___ COPD
___ Chronic cough
___ Oxygen use

DIGESTION:
___ Ulcer
___ Irritable Bowels
___ Diarrhea
___ Constipation

URINARY:
___ Kidney Infection
___ Kidney Failure
___ Frequent Urination
___ Bladder Infection
__Urinary Tract Infection

NERVOUS SYSTEM:
___Headaches/migraines
___ Head Injury
___ Alzheimer's
___ Confusion
___ Dementia
___ Dizziness
___ Multiple Sclerosis
___ Stroke / TIA
When?_____

MUSCULAR/SKELETAL
___ Arthritis
___ Joint Pain
___ Back Pain
___ Arm Weakness
___ Difficulty Walking

ENDOCRINE:
___ Diabetes Type 1/2
Diagnosed Year: _____
___ Hypothyroid
___ Hyperthyroid
___ Hypoglycemia

IMMUNE SYSTEMS
___ Rheumatoid Arthritis
___ Crohn's Disease
___ AIDS/HIV
___ Lupus
___ Allergic Disorder

SOCIAL:
___ Anxiety
___ Depression

Tobacco Use:
(Circle One)
Never / Past / Present

Alcohol Use:
Never / Past / Present

Recreational Drugs Use:
Never / Past / Present
Type: _____

Additional notes:

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Low Vision Survey: Circle all that apply or fill in the blank.

Symptoms:

Blurry Vision	Central Vision Defects	Peripheral Vision Loss	Light Sensitivity
Distortion	Contrast Loss	Color Blindness	Headaches
Double Vision	Fatigue/Strain	Visual Hallucinations	Night Blindness

What daily activities are most affected by your vision loss?

_____

_____

Living Situation: Alone W/Spouse W/Family W/Friends Assisted Living
Occupation:_____ Retired
Social Activities: _____

_____

Do you have any VISUAL difficulty with the following? (Circle one)

Transportation: Always Frequently Sometimes Rarely Never N/A

Driving Family/Friend Rides Public Transit Paratransit Rideshare

Walking: Always Frequently Sometimes Rarely Never N/A

Seeing Faces: Always Frequently Sometimes Rarely Never N/A

Watching TV: Always Frequently Sometimes Rarely Never N/A

Reading: Always Frequently Sometimes Rarely Never N/A

Phone/Tablet: Always Frequently Sometimes Rarely Never N/A

Computer: Always Frequently Sometimes Rarely Never N/A

Cleaning: Always Frequently Sometimes Rarely Never N/A

Cooking: Always Frequently Sometimes Rarely Never N/A

Personal Care: Always Frequently Sometimes Rarely Never N/A

Hobbies: Always Frequently Sometimes Rarely Never N/A

Glare: Always Frequently Sometimes Rarely Never N/A

Dim Lighting: Always Frequently Sometimes Rarely Never N/A

Additional Notes:_____

_____

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Please provide an updated medication list to the front desk staff. Otherwise, fill in below.

Medication	**Dosage**

Allergies to Medications:

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FINANCIAL RESPONSIBILITY POLICY AND CONSENT

I hereby authorize ViewFinder Low Vision Resource Center to process claims to my insurance company or responsible party for healthcare services and product sales. Payment is due at the time of service, except when contracted with medical insurance.

I acknowledge that I am responsible for knowing the benefits and restrictions of my insurance policy, including special HMO policies with Medicare and coverage for "out of network" services or "non-participating provider" services. If my primary or supplemental insurance(s) do not pay the remaining balance of my charges, the balance is my responsibility. Accounts not paid within 90 days may be sent to collections at an increased rate.

I acknowledge that the refraction, a test to determine the prescription of eyeglasses or other optical Low Vision devices, is not covered by most medical insurances. This $60 fee is due at the time of service and does not include fees for medical examination, diagnostic testing, or Low Vision consultation.

By signing below, I acknowledge that I have read, understand, and consent to the above Financial Responsibility Policy.

Signature: _____ Date: _____

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PRIVACY POLICY AND CONSENT

I hereby authorize ViewFinder Low Vision Resource Center to disclose personal health information for to obtain payment for healthcare services and product sales, to perform healthcare services, and to communicate with my other healthcare providers.

I acknowledge that personal medical information may be recorded on the answering machine or text messages of the telephone numbers I have listed or via my email address.

I give permission to use the name(s) listed below as my emergency contact(s) and/or to share my health information with via telephone, email, or in person:

1. Name: _____ Relationship: _____
   Phone: _____
2. Name: _____ Relationship: _____
   Phone: _____
3. Name: _____ Relationship: _____
   Phone: _____

A copy of the HIPAA Notice of Privacy Practices is available upon your request. It is also located on our website.

Signature: _____ Date: _____

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☐ **Yes** ☐ **No** Do you have a Power of Attorney to assist in your medical care decisions?

Name: _____ Relationship: _____

Phone: _____

Signature: _____ Date: _____

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

Name: _____ Relationship: _____

Phone: _____

The 2024 FTC Ophthalmic Practice Rules require us to keep a copy of your signature on file when you get a paper prescription or when you give us permission to send your prescription electronically.

I hereby authorize my glasses and contact lens prescription to be sent to me electronically instead of receiving a paper copy.

Signature: _____ Date: _____

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Medical Records Release

To:_____

I hereby authorize my primary care provider, eye care providers, and other medical providers to release to ViewFinder Low Vision Resource Center any information including diagnosis and records of any treatment or examination rendered to me during the period from _____ to _____.

Please fax records to 480-854-1864 or mail to:

1830 S Alma School Rd #131
Mesa, AZ 85210

Patient Name: _____

Date of Birth: _____/_____/_____

Patient Signature: _____

Date: _____/_____/_____