ViewFinder
Low Vision Resource Center
1830 S Alma School Rd #131
Mesa, AZ, 85210
(480)924-8755

Prepare For Your Low Vision Consultation

Please fill out the online HIPAA-secure paperwork at this address to import directly to your medical record:

https://www.viewfinderlowvision.com/new-patient-forms

Otherwise, fill out and bring a ***completed*** paper copy of the following forms to your appointment. If you are unable to complete the paperwork at home, please arrive 30 minutes early for assistance from the front desk staff.

Please bring your insurance cards to all appointments.

Bring your current eyeglasses, magnifiers, and other vision aids.

A Low Vision Consultation can take up to two or three hours to complete. Bring a copy of your most recent eye exam report to allow a focus on low vision devices and tools during your consultation. If you have not been seen by an eye doctor within the last 12 months, please arrange a driver and any other plans needed for a dilated eye exam during your first appointment.

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.

ViewFinder
Low Vision Resource Center

1830 S Alma School Rd #131
Mesa, AZ, 85210
(480)924-8755

Patient Registration Information

Name: _____

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

Social Security #: __ __ __ - __ __ - __ __ __ __

Address: _____ **Apt. #** _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____

Email address: _____

Primary Care Physician: _____

Address: _____

Phone: _____ **Fax:**_____

Date of Last Exam: _____/_____/_____

Primary Eye Doctor: _____

Address: _____

Phone: _____ **Fax:**_____

Date of Last Exam: _____/_____/_____

Retinal, Glaucoma, Cornea, Neuro-Ophthalmology Specialist:

_____

Address: _____

Phone: _____ **Fax:**_____

Date of Last Exam: _____/_____/_____

ViewFinder
Low Vision Resource Center

1830 S Alma School Rd #131
Mesa, AZ, 85210
(480)924-8755

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:

ViewFinder
Low Vision Resource Center
1830 S Alma School Rd #131
Mesa, AZ, 85210
(480)924-8755

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:

ViewFinder
Low Vision Resource Center
1830 S Alma School Rd #131
Mesa, AZ, 85210
(480)924-8755

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)

Driving:	Always	Frequently	Sometimes	Rarely	Never	N/A
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

ViewFinder
Low Vision Resource Center

1830 S Alma School Rd #131
Mesa, AZ, 85210
(480)924-8755

Additional Notes:_____

_____

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

Medication	Dosage	Medication	Dosage

Allergies to Medications:

_____ _____

ViewFinder
Low Vision Resource Center
1830 S Alma School Rd #131
Mesa, AZ, 85210
(480)924-8755

_____ _____
_____ _____

FINANCIAL RESPONSIBILITY POLICY

Unless we are contracted with your insurance carrier, payment is due at the time of service. As a courtesy, we will bill your insurance on your behalf and will reimburse you, should your services be covered.

If you carry an HMO insurance policy along with Medicare, the HMO plan takes over as your primary insurance. HMO insurance policies MAY OR MAY NOT COVER Low Vision consultations. Please contact your HMO provider to discuss your covered benefits.

You are responsible for knowing the benefits and restrictions of your insurance policy. Some insurance companies may not cover "out of network" services or "non-participating provider" services. **Your supplemental insurance may not pay the remaining balance of your charges, in which case the balance is your responsibility.**

A Low Vision consultation normally includes a refraction. This is a test to determine the power of eyeglasses or other optical Low Vision devices. The charge for this test is **$60.00** and is **not covered by most insurances**. **Please note that this is only a portion of the Low Vision consultation and will be collected at the time of service.** The complete consultation fee is determined by the amount of time the doctor spends with the patient and/or the tests performed.

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

ViewFinder
Low Vision Resource Center

1830 S Alma School Rd #131
Mesa, AZ, 85210
(480)924-8755

Signature: _____ Date: _____

DELINQUENT ACCOUNTS

By signing below, I acknowledge that in the event my insurance company does not pay for the services I receive, it is my responsibility to provide prompt payment to ViewFinder Low Vision Resource Center.

I understand that if my account becomes 90 days past due, ViewFinder will send my account to a collection company for resolution. All delinquent accounts that are sent to our collection agency will be increased in amount owed by 40% to cover our collection fees.

Signature: _____ Date: _____

INSURANCE AUTHORIZATION

I hereby authorize ViewFinder Low Vision Resource Center to release any medical information necessary to process my claim to my insurance company.

Signature: _____ Date: _____

ViewFinder
Low Vision Resource Center
1830 S Alma School Rd #131
Mesa, AZ, 85210
(480)924-8755

PRIVACY POLICY AND CONSENT

While providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information to treat you, obtain payment for our services and conduct health care operations involving our office.

When you sign this consent document, you signify that you agree that we can and will disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. Under the privacy policy, we cannot disclose your information without your consent.

☐ **Yes** ☐ **No** I give permission to ViewFinder to leave personal medical information on the answering machine of the telephone numbers I have listed or via my email address.

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

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

Signature: _____ Date: _____

ViewFinder
Low Vision Resource Center

1830 S Alma School Rd #131
Mesa, AZ, 85210
(480)924-8755

NOTICE OF PRIVACY PRACTICES

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

Please check your preference:

☐ **Yes I would like a copy** ☐ **No I do not want a copy**

☐ **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: _____

ViewFinder
Low Vision Resource Center
1830 S Alma School Rd #131
Mesa, AZ, 85210
(480)924-8755

24 HOUR CANCELLATION AND "NO SHOW" FEE POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, ViewFinder Low Vision Resource Center reserves the right to charge a fee of $60.00 for all missed appointments ("no shows") and appointments which, without a compelling reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Signature: _____ Date: _____

In order to securely communicate confidential Patient Health

ViewFinder
Low Vision Resource Center
1830 S Alma School Rd #131
Mesa, AZ, 85210
(480)924-8755

Information, a **Patient Portal** has been registered to you through our office. You will receive an automated email to the address you provided today with a link to your Patient Portal. You will be asked to create a Username, Password, and Security Question for future access. Summaries of your vision examinations will be uploaded to this Patient Portal, where you may view, download, and share the documents at your convenience.

Glasses and Contact Lens Prescriptions

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: _____

Medical Records Release

ViewFinder
Low Vision Resource Center

1830 S Alma School Rd #131
Mesa, AZ, 85210
(480)924-8755

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: _____/_____/_____

Witness: _____