Pediatric Form

Name_____ Preferred Name_____

Mother's Name_____ Father's Name_____

Date of Birth_____Age_____ Height_____Weight_____Male/Female/Other

Cell Phone_____ May we leave a message? Yes/No

Email address_____ May we email you? Yes/No

Address_____Zip:_____

School_____ Grade_____

Name of Family Physician_____ City_____

Date of last physical check up_____ Preferred Pharmacy_____

Emergency Contact_____

EYE HISTORY

Date of last exam_____ By whom_____

Has your child ever experienced, been diagnosed with or treated for any of the following?

❑Blurry Vision
❑Burning
❑Cataracts
❑Crossed Eye/Eye Turn
❑Double Vision
❑Dryness
❑Eye Infections
❑Eye Injury
❑Flashes of Light
❑Floaters/Spots
❑Glare
❑Glaucoma
❑Halos
❑Iritis/Uveitis
❑Itchiness
❑Lazy Eye
❑Swelling
❑Loss of Vision
❑Macular Degeneration
❑Retinal Detachment
❑Sunlight Sensitivity
❑Trouble Seeing at Night
❑Vision Fluctuation
❑Watering Eyes

Other_____

Did your child's school or pediatrician find any evidence that visual disturbances may be present? ❑ yes ❑ no

If yes, what? _____

Do you plan on getting new glasses today? ❑yes ❑no ❑If Rx has changed

Do you currently wear glasses? ❑ Yes ❑No Age at First Pair of Glasses_____

Are you satisfied with your vision? ❑ Yes ❑No

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Television Viewing:

How much_____ How often_____ Viewing distance_____

MEDICAL HISTORY
Have you ever been diagnosed or treated for the following health problems?

**By checking this box ❑ , you confirm your child has never been diagnosed with any medical condition*

❑Allergies
❑Anemia
❑Arthritis
❑Bronchitis
❑Cancer
❑Chronic Cough
❑Epilepsy
❑Diabetes
❑Dizziness
❑Dry Mouth
❑Emphysema
❑Headaches
❑Heart Disease
❑High Blood Pressure
❑High Cholesterol
❑HIV +/AIDS
❑Irritable Bowel/Crohn's
❑Joint/Muscle Pain
❑Kidney Issues
❑Migraines
❑Nursing (currently)
❑Psychological
❑Pregnant (current/trying)
❑Rosacea
❑Seizures
❑Sinus Issues
❑Thyroid

Other_____

Current Medications (RX or over the counter)_____

_____

**We can photocopy your list of medications if you have them*

Allergies to medications? ❑No ❑Yes- What medications?_____
Have you had any eye surgeries? ❑No ❑Yes- what?_____

Has your child experienced any of the following?

Confusing letters or words?	❑yes ❑no	Reversing letters or words?	❑yes ❑no
Skips, rereads or omits words?	❑Yes ❑no	Vocalizes when reading silently?	❑yes ❑no
Avoids near tasks?	❑yes ❑no	Short attention span?	❑yes ❑no
Read slowly?	❑yes ❑no	Uses Finger as marker?	❑yes ❑no
Poor reading comprehension?	❑yes ❑no	Writes or prints poorly?	❑yes ❑no
Tires easily?	❑yes ❑no	Poor motor coordination?	❑yes ❑no
Difficulty catching/hitting ball?	❑yes ❑no		

Nutrition Information

Current Diet: ❑ Excellent ❑ Good ❑ Fair ❑ Poor
Does your child crave sweets? ❑ Yes ❑ No
Low energy? ❑ Yes ❑ No

Is your child: ❑ Moderately active ❑Extremely active
Periods of high energy? ❑ Yes ❑ No

Pediatric Form

Developmental History

❑ Normal birth ❑ Premature Birth: If yes when?_____

❑ Complications at birth? If Yes, what? _____
❑ Crawled normally ❑ Did not crawl for long ❑ Crawled longer than usual
❑ Walked at ____ Months

School

Age entering Kindergarten:_____ Does your child like school? ❑ yes ❑ No Teacher? ❑ yes ❑ no

School work is? ❑ above average ❑ average ❑ below average

Do you feel your child is working up to potential? ❑ yes ❑ no

Does teacher feel your child is up to potential? ❑ yes ❑ no

What subjects come easy to your child? _____

Does your child like to read? ❑ yes ❑ no Voluntarily? ❑ yes ❑ no What do they like to read? _____

Specfically, describe school difficulties: _____

Has your child repeated any grades? ❑ yes ❑ no Which?_____

Changed Schools often? ❑ yes ❑ no When?_____

Does your child seem to be under tension or extreme pressure when doing school work? ❑ yes ❑ no

FAMILY MEDICAL HISTORY

Is there a family history of the following?

	Relationship:		Relationship:
❑Diabetes	_____	❑Blindness	_____
❑Heart Disease	_____	❑Glaucoma	_____
❑Cancer	_____	❑Lazy Eye/Eye Turn	_____
		❑Macular Degeneration	_____

Do you agree to be dilated today to have the health of your eyes thoroughly examined by Dr. Dunn?
❑Yes ❑Unsure, I would like to talk to the doctor about it.

The information I have provided, to the best of my knowledge, is accurate. _____
Patient or guardian signature

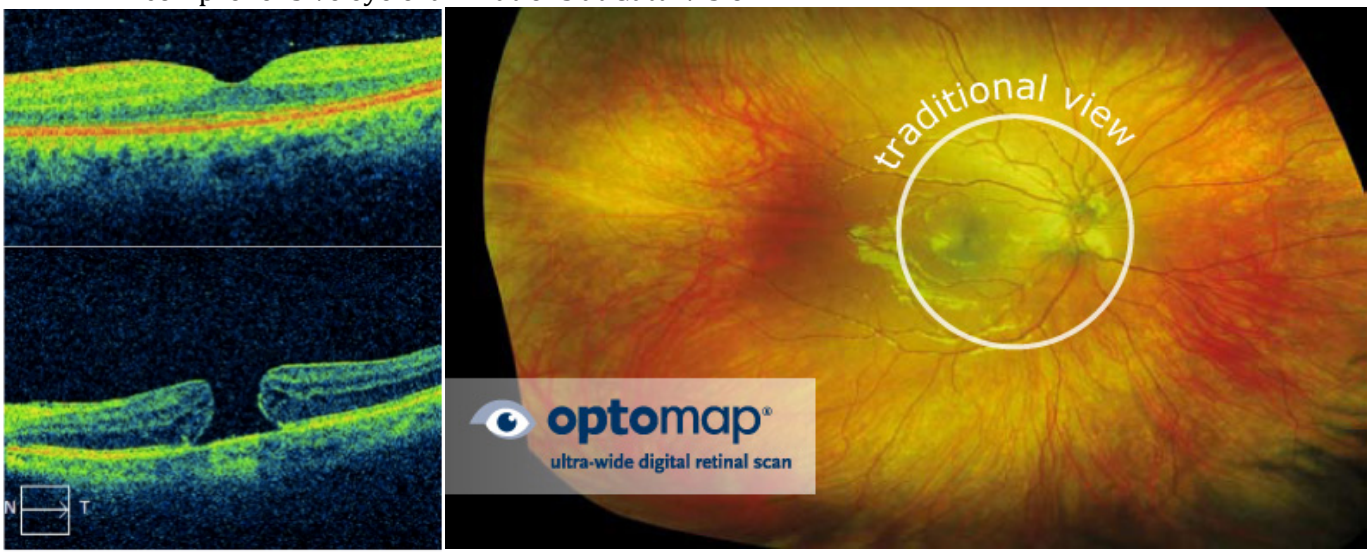
Doctor Reviewed_____

Preventative and Wellness Consent

In our continued efforts to provide the highest level of eye care, and to bring the most advanced technology available to our patients, Gatti Vision is proud to offer our patients an advanced Preventative and Wellness Screening using our state of the art technology.

Analyzing these extremely high-resolution images is an excellent technique for diagnosing and monitoring diseases like GLAUCOMA, MACULAR DEGENERATION or DIABETIC RETINOPATHY.

Imaging performed today establishes a baseline for future exams. This makes it possible for Dr. Dunn to detect any changes in your eyes over time with extreme precision. It is now the standard of care to perform retinal imaging during comprehensive eye examinations at Gatti Vision.



_____I accept this standard of care for **$25.00**
This is not covered by insurance and can be paid by cash, check or credit card

_____I decline the advanced imaging against my doctor's recommendation.

_____ _____
Signature *Date*

15405 SW 116TH AVE UNIT 204 | KING CITY OR, 97224 | (971) 371-3927

Written Financial Policy

Thank you for choosing Gatti Vision LLC. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, or accepted credit cards

- CareCredit healthcare credit card. CareCredit is the preferred healthcare credit card providing special financing and payment options[1*] for out-of-pocket medical expenses. Ask about how the CareCredit healthcare credit card can help you.

We offer a 12% courtesy adjustment to uninsured patients who pay day of service for their vision care.

Please note:

It is customary to pay for professional services when rendered. However, **if you have a medical problem then we will bill your medical insurance on your behalf**. During your comprehensive exam, a refraction will be performed. A refraction is a measurement of the lens power necessary to prescribe glasses or other corrective lenses. Most medical insurance plans, including Medicare, do not cover routine refractions or routine eye exams (when no medical eye problem is known or suspected). Medicare, and most other insurance plans, insists that we charge separately for that portion of the examination, since it is not a covered service. You will receive an explanation of benefits from them itemizing your responsibilities. You will be responsible for any co-payments, deductibles or non-covered services as determined by your insurance company.

Contact lens exams are not part of comprehensive exams. There may be an additional fee for these exams and fittings if they are not covered by your insurance.

If you have a separate plan that covers routine or annual eye examinations and/or hardware, please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan. We will bill your vision plan as above.

We are a Medicare participating practice. If you are a Medicare Beneficiary, we will file a claim for you. You will be responsible for the annual deductible and the 20% co-payment.

MINORS ACCOMPANIED BY AN ADULT; The adult accompanying a minor and his/her parents (or guardian) are responsible for payment upon completion of your exam or consultation.

[1*]Subject to credit approval

In accordance with our contract and with your insurance provider, we are responsible for collecting, and you are responsible for paying, co-payments after your exam.

Gatti Vision LLC requires payment after the exam or consult.

Gatti Vision LLC requires a payment be made in full prior to the order of your optical purchases.

Gatti Vision LLC requires a fee for the refraction of $35 (if your insurance does not cover it). *See above

Gatti Vision LLC will verify your insurance eligibility prior to your appointment.

If you have any questions, please do not hesitate to ask. We are here to help you get the quality care you want or need.

*However, if we do not receive payment from your insurance carrier within 15-30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Vision vs. Medical Insurance

1.) Vision Insurance – Examples: VSP, EyeMed, Spectera, etc.

- Routine vision exams with copay
- Hardware and contact lenses with copay
- Does not cover medical eye care (dry eyes, allergies, injuries, etc.)

2.) Medical Insurance – Examples: BCBS, Medicare, Cigna, Providence, etc.

- Used for medical eye care (diabetes, dry eyes, allergies, injuries, infections, etc.)

If a medical eye condition is discovered during your comprehensive vision exam, Dr. Dunn may ask you to return for a progress evaluation. If you have both types of insurance, we will bill the insurances appropriately. We will try to minimize your out-of-pocket expense. If some fees are not covered by insurance you will be responsible for them. For example, deductibles, co-pays, and non-covered services as allowed by our insurance contract.

Please provide all insurance information you may have by time of service so that our staff can record all of your coverages. We need to have a copy of all insurance cards on file in case we need to bill your insurance for future exams. If insurance is not provided, fees will be the responsibility of the patient.

By signing below, you acknowledge that you have read and understand this document.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

RETURN/EXCHANGE POLICY

Gatti Vision LLC does not allow returns or exchanges on frames, reading glasses, or sunglasses. This includes all accessories and cleaners. **All sales are final.** We take the time to help you pick out the best products and ensure you are satisfied before leaving the office.

Gatti Vision LLC does not allow returns or exchanges on artifical tears, warm compresses, Alaway, Omega 3s, lid scrubs, or contact lens solution. **All sales are final.** We are a medical practice and therefore cannot allow any returns or exchanges - whether opened or unopened.

By signing below, you understand that once purchased, the product is unreturnable.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)