TRANSFORMING THE
LIVES OF PEOPLE WITH
SIGHT LOSS

707.523.3222
4539 Occidental Rd.
Santa Rosa, CA 95401
www.earlebaum.org

IMPORTANT

Please bring the following with you on the day of your Low Vision Appointment:

Medicare Card

&

Supplemental Ins. Card

&

Any form of Government-issued I.D. card
(Driver's license, State I.D., Passport)

ALSO
PLEASE BRING ANY VISION AIDS YOU ARE CURRENTLY USING
(Glasses, Hand magnifiers, etc.)

PLEASE READ CAREFULLY

Earle Baum Center has set aside 2 hours for your in-depth Low Vision Clinic Exam. EBC requires 72 hours' notice for cancellation of a scheduled Clinic Appointment. In the event the client fails to notify the center with at least 72 hours' notice, the client will be charged $100.00. This amount IS NOT covered by Medicare.

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Welcome to the Earle Baum Center Low Vision Clinic. You have been referred for low vision assessment and rehabilitation. During your initial visit, we will evaluate your current visual capabilities and explore both optical (such as special glasses or magnifiers) and non-optical methods to help you compensate for your sight loss.

Tests will be performed to determine the strengths and weaknesses of your current vision and to determine if you would benefit from training to relearn your visual skills. We hope to help you use your remaining vision more effectively. In order to best accomplish this objective, you should think about what specific visual tasks give you trouble. This will help guide your rehabilitation. It may require multiple visits to best fulfill your needs.

It is our goal, through our joint efforts, to help you maintain your independence. We are not replacing your regular eye care professional or treating your eye disease. Please visit your eye care professional to determine your eye health before scheduling a low vision evaluation.

Your initial visit will be scheduled for 2 hours. The Follow-Up appointment is typically 1 hour. It is best to have a family member or friend accompany you to the examination.

Unfortunately, Medicare does not cover the cost of the low vision refraction fee nor vision aids. However, Medicare will cover approximately 80% of the evaluation and training portions.

As a provider of services and on your behalf, the EBC will submit all Medicare claims directly to their office as well as any supplemental insurance. If there is a portion of the examination that is not covered under Medicare and supplemental insurance, <u>then an invoice will be sent to you indicating the balance due</u>. If you do not have Medicare or you have a different plan where we are unable to submit Medicare claims through our portal system, we will be happy to provide you with the necessary paperwork that you will need to process your claim directly with your insurance company.

PLEASE NOTE: Kaiser Santa Rosa Clients have two options regarding a low vision exam.

1. **You may opt for Kaiser's Low Vision 60 exam, and then have your Follow-Up appointment here at the Earle Baum Center. This is a standing arrangement with Kaiser Santa Rosa, whereby upon the conclusion of the Low Vision 60 exam, Kaiser refers to EBC for the Follow-Up. Please contact your primary eye care provider at Kaiser for more info.**

OR

2. **You can forego KAISER's exam and have both appointments at our Center (2-hour low vision exam, and 1-hour follow-up). In this scenario, the client will be responsible for payment in full. An invoice will be sent to the client. The cost to the Center for the Low Vision Clinic is $329.67.**

If you have any questions, please contact Cindy Peterson at (707) 636-9929.

As a convenience, you can FAX your completed Survey to 707-230-6211, *att. Cindy Peterson.*

The Earle Baum Center offers several core services to help those dealing with sight loss, including:

Orientation & Mobility

Assistive Technology Training

Adjustment to Disability Counseling

Independent Living Skills

If you are interested in hearing more about any of these services, please indicate below, and an INTAKE INTERVIEW will be arranged.

INTAKE INTERVIEW YES_____ NO_____

There is *NO FEE* for this Interview.

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Office Use Only:
- ☐ Information
- ☐ Clinic

Your Low Vision Clinic Survey

To allow us to assist you quickly, please return this survey as soon as possible, *preferably no later than 1 week after you receive it*.

We would like you to complete this questionnaire and mail it back to the Earle Baum Center in the envelope provided.

Your appointment will be scheduled after the Earle Baum Center receives this completed form.

The questions in the survey may seem excessive or unrelated to your sight loss, but the information you provide will help us develop a rehabilitative program that addresses your total care.

Do you have insurance? Private / Medicare

Insurance/Medicare #:

Supplemental: ______________ #_______________

Client's Name: _________________________

Date: _______________

Activities of Daily Living: Circle on scale from easy to difficult.

	Easy				Difficult
Reading	1	2	3	4	5
Writing	1	2	3	4	5
Face recognition	1	2	3	4	5
Telephone	1	2	3	4	5
Hearing and speech	1	2	3	4	5
Eating/meal preparation	1	2	3	4	5
Grooming/self care	1	2	3	4	5
Dressing	1	2	3	4	5
Personal health care	1	2	3	4	5
Driving/transportation	1	2	3	4	5
Shopping	1	2	3	4	5
Personal finances	1	2	3	4	5

General Health Survey

How is your general health?
Excellent Good Fair Poor

Do you have diabetes? ___ If yes, what type?________
Date of diagnosis?_________
What care is required?____________________________

Do you have high blood pressure?_________

What is the cause of your low vision? (include your eye-health diagnosis)

Who is your Ophthalmologist?

Who is your Optometrist?

Who referred you to us?

Do you see a Retina Specialist?
If so, who?

Are you receiving eye injections as part of your treatment?___________ If so, when was last injection? ____________________When is the next scheduled for? ___________________

Are you currently taking an eye vitamin?
If so, which one?

Have you received low vision services in the past?

Is Glare an issue for you?

Are you currently using any of the following Low Vision devices?

___ Prescription glasses
___ Glare Shields
___ Lighted Magnifiers
___ Video Magnifiers (hand-held & Desktop)
OTHER:

Who is your Primary Care Doctor?

Is hearing or speaking challenging in any way?

If so, do you wear hearing aids?

Do you have assistance organizing/taking your medications?

Do you have other medical challenges which require special care?

Is your mobility challenging?

Do you use a walker or cane for stability?

Do you have tremors, paralysis or weakness in your hands?

How is your endurance while doing a focused activity (Sitting at a desk reading, writing, etc.)?

How is your memory?________ How is your emotional state?______________ (GOOD, FAIR, POOR)

Employed/Retired? What is/was your Occupation?

Are you a Veteran?

Do you live alone? Yes

If not, who do you live with?

If you live alone, do you wear a medic alert device?

Describe your residence (apartment, retirement community, private residence, etc.): Private residence

Do you deal with stairs while at home?

Are you currently driving?

What transportation do you use for appointments, shopping and other activities?

Do you rely upon large print, magnification, or special lighting in order to read comfortably?

What kind of reading do you need/want to be able to do? (mail, novels, newspaper, food labels, etc.):

Do you watch television?

What is the size of the screen?

How close do you sit?

How much time do you spend on the computer?

Are you able to type and use the computer with ease?

What are your hobbies?

How has your life changed since the onset of your sight loss?

Due to your sight loss, what activities do you miss most?

We would appreciate your sharing any ideas that have helped you adapt to your change in vision.

What do you do for fun?

PERSONAL EYE INFORMATION

Date of last eye exam: ___________ Dilated? _________

Do you have:

Glaucoma? Y/N

Macular Degeneration? Y/N

Cataracts? Y/N

Other eye problems: Y/N What kind? ___________________________

Have you had any eye operations? Y/N

Type _____________________________ Date___________

Have you had an eye injury? Y/N Kind_____________________________

_________________________________Date___________

Do you wear glasses? Y/N Contact lenses? Y/N Type _________________

GENERAL MEDICAL INFORMATION

Do you have problems with any of these systems? *(please circle all that apply)*

Gastrointestinal	Neurological Impairment	Developmental Disability
Ears/Nose/Throat	Genitourinary	Diabetes
Cardiovascular	Musculoskeletal	Blood/Lymph
Respiratory	Integumentary (skin)	Allergic/immunologic

Please Explain____

Allergies: Y/N Allergic to what? _______________________________________

What happens:____

Medication Allergy Y/N What happens? ________________________________

Headaches: Y/N

Other health problems?

____

Have you had any operations? Y/N What Kind? ___________________________

When? ____

Do you use cigarettes/tobacco? Y/N __________Alcohol? ______

Do you have an Advance Directive for health care? ________________

FAMILY HISTORY

High blood pressure   Y/N Relation: ___________________________________

Diabetes   Y/N   Relation____

Macular Degeneration Y/N Relation___________________________________

Retinal detachment   Y/N Relation___________________________________

Glaucoma Y/N Relation____

Cataracts   Y/N Relation____

Other eye condition(s) Y/N What kind? ________________________________

Relation ____

Please list any **Prescription AND over-the-counter Medications** & supplements you are currently taking (attach to survey, if necessary).

IMPORTANT!

PLEASE FILL OUT & SIGN THE FOLLOWING INSURANCE INFORMATION AT BOTTOM

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ MALE ☐ FEMALE

First Name MI Last Name Preferred Name

Street Address City State Zip

Date of Birth Home Phone w/area code Day Phone Mobile#

Family Doctor Spouse or Parent(s) Name Person Responsible for Account

Emergency Contact Emergency Phone

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company City State Zip

☐ M ☐ F

Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other

☐ Full Time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company City State Zip

☐ M ☐ F

Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insure
☐ Self ☐ Spouse ☐ Child ☐ Other

I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to the undersigned supplier for services rendered.

The refraction fee is not a covered service by most medical insurance companies. I understand that I am responsible for all co-pays and non-covered services at the time of service.

Failure to provide a current legible insurance card will require payment at the time of service. There is a $25.00 returned check fee.

Signature Date

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Please be prepared
to sign the following documents upon your arrival during check-in

Earle Baum Center Notice of Privacy

Earle Baum Center Waiver of Liability

Earle Baum Center of the Blind
Photograph and Publicity Release Form

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Earle Baum Center Notice of Privacy Policy

At the Earle Baum Center, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice, and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal health care operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may want to call you and remind you of your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the phone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we will not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal use.

As we need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail you files for you. You have the right to see or receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.

You have a right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office at (707) 523-3222,

ACKNOWLEDGEMENT

I have received a copy of Earle Baum Center's privacy practice. Date__________________________

Signed____ Print __________________________

If signing as a parent or guardian, please note the name of the patient___________________________

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Earle Baum Center
Waiver of Liability

This Waiver of Liability and Release must be signed by anyone receiving or providing virtual/phone services from Earle Baum Center of the Blind (EBC) at the following location: 4539 Occidental Road, Santa Rosa, in the community, distance learning, client's home and workplace, as well as, while being transported in a vehicle provided or procured by the EBC. Participation in services including volunteering is prohibited unless this form has been signed and returned to the EBC. **This consent shall be valid if the signee is active with EBC**
I am in satisfactory physical, mental and emotional condition and may engage in all activities associated with the services I am receiving at my own risk. At any time that I am receiving services provided by EBC, I hereby consent, **in case of emergency** to have a qualified practitioner, e.g. physician, nurse or EBC staff member treat me while waiting for the 911 response team to arrive. **In case of emergency,** permission is given to designated EBC staff to contact emergency medical services and/or secure treatment for the undersigned.

1) I understand and accept the EBC reserves the right to require documentation of my vision loss if EBC staff determines such information is considered necessary for assessment and/or the provision of services/training.

2) I hereby waive any and all claims that I or my heirs may have against EBC, its Directors, Officers, Employees, Independent Contractors, Volunteers, and/or Agents for any injuries or property damage which may arise while I am receiving EBC services, including transportation provided or procured by EBC, at or while In route to any of the locations referenced above in paragraph 1. I acknowledge that this waiver includes any claims for personal injuries or property damage caused by or arising out of the **negligence** of EBC or its Directors, Officers, Employees, Independent Contractors, Volunteers, and/or Agents.

3) I have informed EBC of any medical, mental or emotional conditions and/or medications that they should be aware of during my participation in programs/services with the EBC.

4) **PLEASE READ CAREFULLY- EBC requires 72 hours' notice for cancellation of scheduled instruction. After 1 (one) unexcused cancellation the client may be reviewed for further services. EBC may assess the client our established hourly rate for unexcused cancellations ranging up to $50 per hour. (*This applies only to those receiving Fee for Service Training*.)**

I understand this Waiver of Liability and Release constitutes the entire understanding between the parties referenced herein with respect to matters set forth herein. There are no oral representations, arrangements or agreements between the parties referenced herein other than those contained verbatim in the Waiver of Liability and Release. This Waiver of Liability and Release shall be interpreted in accordance with and governed by the laws of the state of California.

Name: (**PRINT**)____ Date: _______________

Signature or Verbal Approval*: ____

Name of Person reading document to Signer: (Print) _____________________________

Signature or Verbal Approval of reader: _______________________________________

- **Verbal Approval* must include an email sent to or received by signer noting approval**

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Earle Baum Center of the Blind Photograph and Publicity Release Form

I, ___________________________, give Earle Baum Center permission to use my name, quotes, likeness, image, voice, and/or appearance as such may be embodied in any pictures, photos, video/audio recordings, interviews taken or made on behalf of Earle Baum Center. I agree that Earle Baum Center will have complete ownership of these photos, etc., including the entire copyright, and may use them for any purpose consistent with Earle Baum Center's mission. These uses include, but are not limited to illustrations, bulletins, exhibitions, videos, reprints, reproductions, publications, advertisements, fundraising material, and any promotional or educational materials in any medium now known or later developed, including on the Internet. I acknowledge that I will not receive any compensation, etc. for the use of such pictures, etc., and hereby release Earle Baum Center and its agents and assigns from any and all claims which arise out of or are in any way connected with such use.

I have read and understood this consent and release.

I give my consent to Earle Baum Center to use my name and likeness to promote Earle Baum Center and/or their activities.

Name: (**PRINT**)____ Date: ________________

Signature or Verbal Approval*: ____

Name of Person reading document to Signer: (Print) _______________________________

Signature of Verbal Approval* from reader: _______________________________________

- *** Verbal Approval must include an email sent to or received by signer noting approval**

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client's Name: ______________________ Date of Birth: ______________

Previous Name: ______________________________________

I request and authorize ______________________________________

to release healthcare information of the client named above to:

Name: Cindy Peterson, Director of Low Vision Clinic

Company: Earle Baum Center of the Blind Fax: 707-230-6211

Address: 4539 Occidental Road

City: Santa Rosa State: CA Zip Code: 95401

This request and authorization applies to:

Current comprehensive chart notes from eye doctors.

Client Signature: ______________________ Date Signed: ______________

Print Client Name:

(Or Parent if Client is a Minor)