Earle Baum Center Transforming the Lives of People with Sight Loss
4539 Occidental Rd. Santa Rosa, CA 95401 *(707) 523-3222* *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****

The Earle Baum Center has set aside 2 hours for your in-depth Low Vision Clinic Exam. The 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.

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, then an invoice will be sent to you indicating the balance due. 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 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, 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, we will submit to the clients' primary and supplemental insurance companies per our usual process. Please note, however, that there may be a balance due after reimbursement, in which case an invoice will be sent to the client. The cost of the 2-hour Low Vision Exam is $322.76. The cost of the 1-hour Follow Up Appointment is $50.00.**

If you have any questions, please contact Nick O'Riley at (707) 636-9929.

As a convenience, you can FAX your completed Survey to: 707-230-6211, *att. Nick O'R*

Your Low Vision Evaluation

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?

What low vision aids are you currently using?

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?

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.):

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	Nervous	Mental
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 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

Social Security Number Date of Birth Home Phone w/area code Day Phone

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

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_____