DALLAS SERVICES

_____
Appointment Date

APPLICATION FOR VISION SERVICES
LOW VISION CLINIC

Receiving Traditional Medicaid? YES ____ NO ____
(If YES, must use Medicaid)

I request help from Dallas Services in securing vision examination and/or eye glasses for my child.

Student's Name _____ **Social Security #** _____
Nombre de Estudiante Numero de Seguro Social

Address _____ Apt# _____ **City** _____ **State** _____ **ZIP** _____
Domicilo Ciudad Codigo Postal

Home Phone _____ **Work Phone (Parent's)** _____

Birthday _____ **Age** _____ **School** _____ **Grade** _____
Fecha de Nacimiento Edad Escuela Ano Escolar

If student doesn't have SS# write down school ID# _____
Net Monthly Family Income $ _____
Resitos/sueldos de todas los micmbros de su familia por mes
Adjusted Net Monthly Income $ _____
Number of family members _____
Free or reduced lunch program? YES _____ NO _____

For School Nurse Only

Has student failed vision screening **TWICE**? Yes _____ No _____
Dates conducted vision screening _____ _____
(Nurses, please **DO NOT** send student's Medical Referral/Follow-up form to us)
Symptoms or Complaints _____

Parent's Name _____
School Nurse Name _____ Phone # _____
Name of School and School District _____

4242 Office Parkway · Dallas, TX 75204 · 214.828.9900 · (F) 214.828.9901

School District _____ School _____ Nurse _____

RELEASE OF INFORMATION FORM

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

I give my authorization to use or disclose my child's protected health information. I give the authorization voluntarily.

Name of Child: _____

Parent's/Legal Guardian's Name: _____

Home Address: _____ **City:** _____ **Zip Code:** _____

Home Telephone Number: _____

Name the people and organizations that you are authorizing to use and/or disclose protected health information **DALLAS SERVICES, LOW VISION CLINIC**.

Name the people and/or organizations (or kinds of people and/or organizations) that you are authorizing to receive and use your child's protected health information.
SCHOOL DISTRICTS, DIVISION FOR BLIND SERVICES, LION'S SIGHT AND TISSUE FOUNDATION.

HIPAA Compliance Acknowledgment of Receipt

ACKNOWLEDGMENT FORM

I have received the *"Notice of Privacy Practices"* and I have been provided an opportunity to review it.

Name of Child: _____

Parent or Legal Guardian's Signature: _____

Date: _____

DALLAS SERVICES

_____
Appointment Date

APPLICATION FOR VISION SERVICES- *GLASSES ONLY*

I request help from Dallas Services in securing eye glasses for my child.

Student's Name _____ **Social Security #** _____
Nombre de Estudiante Numero de Seguro Social

Address _____ Apt # _____ **City** _____ **State** _____ **Zip** _____
Domicilo Ciudad Codigo Postal

Home Phone _____ **Work Phone (Parent's)** _____

Birthday _____ **Age** _____ **School** _____ **Grade** _____
Fecha de Nacimiento Edad Escuela Grado

Is Student legal resident of the U.S.? YES _____ NO _____
Estudiante es residente legal de los Estados Unidos SI _____ NO _____

If "NO", student school ID# _____
Net Monthly Income $ _____
Resitos/sueldos de todas los micmbros de su familia por mes
Adjusted Net Monthly Income $ _____
Number of family members _____
Free or reduced lunch program? YES _____ NO _____

For School Nurse

Parent's Name: _____

School Nurse Name: _____ Phone #: _____

Name of School and School District: _____

DALLAS SERVICES

REPLACEMENT OR REPAIR OF GLASSES

School District: _____
School: _____

_____ **Replacement of Lost Glasses ($ 30.00 fee)**
_____ **Repair of broken frame ($ 10.00 fee)**

Student's Name: _____
Address: _____
City/Zip: _____
Birthday: _____
Social Security or School ID#: _____
School Nurse: _____
Nurse's Phone #: _____ **Fax #:** _____

DATE SEEN IN LOW VISION CLINIC: _____
(Last visit should not exceed two years or refer for new prescription.
In order to replace or repair glasses, student must have received glasses from Low Vision Clinic)

Include a copy of the eye exam with money order (payable to the Low Vision Clinic) or cash. (If you do not have exam report, please check with your Nurse coordinator)

Low Vision Clinic use only:

_____ Repaired broken frames on _____
_____ Sent to lab on _____
_____ Make appointment to pick out new frames only
_____ Send back to Clinic for eye exam & glasses
_____ Glasses or frame not from Low Vision Clinic
_____ Other _____

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LA FORMA DE LIBERACION DE INFORMACION

Esta forma es de confirmar su autorizacion para utilizar o reveler su informacion protegida de la salud para un proposito especial.

Autorizo la liberacion de medico o otra informacion necessaria para procesar a reclamos al seguranza. Yo autorizo el pago de beneficios medicos directo a Low Vision Clinic.
Yo me doy cuenta de que soy responsible de esos servicios no cubridos por benificios medico.

Firma:_____ **Fecha:**_____

Doy mi autorización a utilizar o revelar mi información protegida de la salud.
Doy la autorización voluntariamente.

Nombre de paciente:_____

Firma de Paciente/Padre o Guardian:_____

Su dirección de calle:_____

Ciudad_____ **Estado:**_____ **Codico Postal:**_____

Su número de teléfono de casa:_____

De cellular:_____

Numero de Seguro Social de Paciente:_____

Las personas y/o la organización que usted autoriza a utilizar y/o revelar información protegida de salud:DALLAS SERVICES LOW VISION CLINIC

Las personas y/o la organizacion que usted autoriza a utilizar y/o reveler informacion protegida de salud:

_____

_____

_____

_____

DALLAS SERVICES

Dallas Services Low Vision Clinic

Dr. Stephanie Fleming, O.D.
4242 Office Parkway
Dallas, TX 75204
Phone: (214) 828-9900
Fax: (214) 828-9901

El Reconocimiento de la Conformidad de HIPPA
Forma de Reconocimiento

He recibido la Nota de Practicas de Intimidad y yo he sido proporcionado y la oportunidad de revisarlo.

Nombre de Paciente: _____

Fecha de Nacimiento de Paciente: _____

Firma de Paciente/Guardian: _____

Fecha: _____

School District _____ School _____ Nurse _____

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Name of Child: _____

Parent or Legal Guardian's Signature: _____

Date: _____

Dallas Services Low Vision Clinic

Children's Eyeglasses Clinic
Appointment Slip

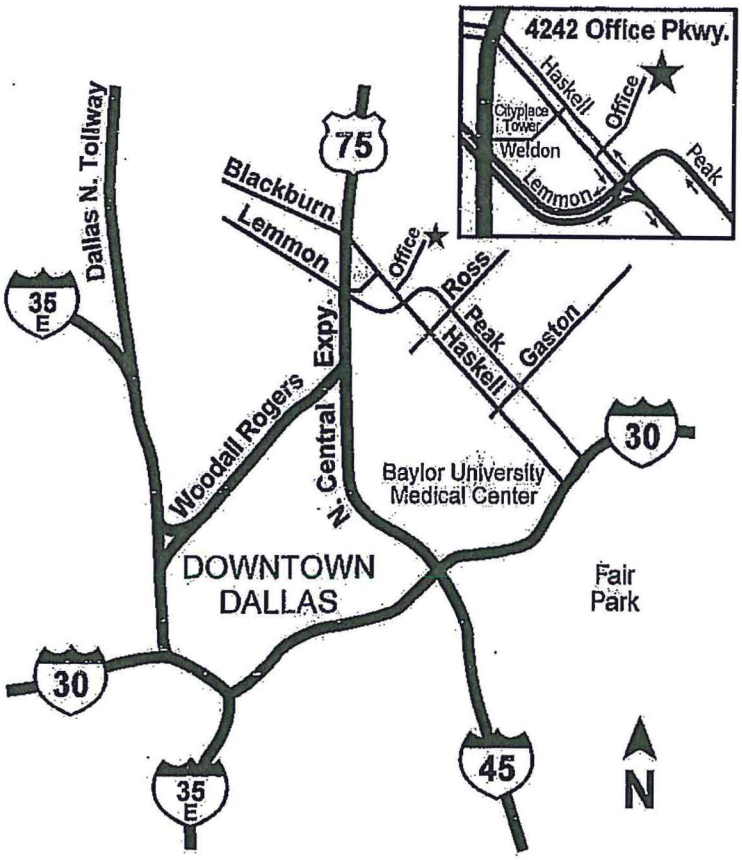
Student's Name/ Nombre del Estudiante

Nurse / Enfermera Phone #

Appointment Date/Fecha de Cita

School/ Escuela

Parents should take this slip with the student to the Clinic
Los padres deben llevar esta forma con el Estuidiante a la Clinica



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