



**VISION THERAPY CENTER  
OF JONESBORO PLLC**

Vision Therapy Center of Jonesboro, PLLC  
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### **ReadAlyzer - electro-oculography**

Patient Name: \_\_\_\_\_ Testing Date: \_\_\_\_\_

You have been prescribed a computerized "ReadAlyzer" assessment to analyze your visual reading. This is an eye-movement recording test to evaluate reading rate, fixations, regressions, rereading, eye teaming between the right eye and left eye and more. (please bring to the evaluation any prescription eyeglasses the patient uses)

The testing fee covers: test and a detailed report of the findings.

If you testing was done in conjunction with the Functional/Developmental testing the findings will also be reviewed during your consultation appointment with the physician.

I understand that a payment in full for \$50.00 is due on or before the testing date.

I am authorizing the "ReadAlyzer" test to be completed.

\_\_\_\_\_  
Patient/Parent/Guardian (if patient is minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff

\_\_\_\_\_  
Date