

EYE THERAPY VISION REHABILITATION CENTER



FINANCIAL POLICY

This is an agreement between Eye Therapy, and the Patient/Responsible party named on this form. In this agreement the words “you,” “your,” and “yours” mean the Patient/Responsible Party. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we,” “us,” and “our” refer to the doctors and staff at Eye Therapy.

Payment for services

You choose to pay with the payment option _____ of the signed financial agreement by the first day therapy is rendered for all services where insurance is not an option.

Satisfaction Guarantee: If at any point you are not satisfied with the service being rendered, you may receive a refund for all services that have not been rendered to that point. The Program of Care and Equipment Fee are not refundable.

Early Completion: If the doctor decides that treatment resulted in resolution of the condition sooner than anticipated, then a refund will be given for all services that have not been rendered. The Program of Care and Equipment Fee are not refundable.

Unpaid Balances: We reserve the right to withhold future visits if your account is delinquent.

Returned Checks: There is a \$20 fee for any checks returned by the bank.

Equipment Replacement Fee: There will be a replacement fee for any equipment that is lost and needs to be replaced. Flippers will be checked out during therapy. There is a \$20 fee for any flipper not returned at the end of therapy.

Missed appointment policy: Patients who miss a Vision Therapy appointment must make up that appointment before their next scheduled progress evaluation. This may mean that you will have an additional therapy appointment in a given week.

Sick policy: If your child is sick with a fever or is vomiting, or has “pink eye” then we ask that you do not bring them to therapy and you will not be assessed the fee if you call as soon as you know this is the case. If your child has a cold with no fever or vomiting and you feel that they are able to do vision therapy effectively that day, the child can come, but we ask that they wash their hands and may be asked to do so throughout their therapy appointment. **If you are too sick to go to school, you are too sick to come to vision therapy.**

Child Check-Out policy: Adults picking up a child younger than 16 years old are required to physically come in and check-out with the front desk.

Late fee: If you are more than 5 minutes late we will remind you of our late fee. The second time you are late there will be an automatic charge of \$15 applied to your account. The third time you are late your spot may be given to another patient.

48 Hour Cancellation Notice: We require 48 hours notice to cancel an appointment. The first time you cancel without proper notice we will give you a reminder of our policy. The second time you cancel without proper notice will result in an automatic \$25 cancellation fee. The third time you cancel without proper notice your spot may be given to another patient.

No Show fee: If you do not show up to your appointment and are unable to give 48 hours notice of a change, there will be a \$25 no-show fee. After 2 no shows your therapy time slot will be given to another patient.

Three Strikes: If you have not completed your home therapy assignments for the week, and there were no unforeseen circumstances, then you will receive a strike. After three strikes your therapy will be terminated.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation during treatment, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Workers' Compensation: We require written approval/authorization by your employer and/or workers' compensation carrier prior to your initial vision therapy visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial vision therapy visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name: _____

Responsible party (If not the patient): _____

Signature: _____ Date: _____

Co-Signature: _____ Date: _____

*If a refund check is needed please write it to: _____