CONDITION OF TREATMENT

1. FINANCIAL AGREEMENT: I understand that in consideration of the services rendered, I am obligated to pay InSight Vision Therapy in accordance with their regular rates and terms. I understand that I am responsible for any charges and that the obligation to pay for routine, medical and vision therapy services may not be deferred for any reason. If the account is referred to any agency for collection, I agree to pay all collection expenses.

2. ASSIGNMENT OF INSURANCE BENEFITS: I hereby recognize that InSight Vision Therapy is not contracted with my insurance company. I understand that it is my responsibility to submit for reimbursement, should I choose to, from my insurance company. The reimbursement should come directly to me, and not to InSight Vision Therapy. InSight Vision Therapy will provide the necessary documentation for this process. I understand that I am responsible for all charges, whether or not they are covered by my insurance company.

3. CONTACT LENSES: Contact lenses are a medical device that fit directly onto the cornea (front surface of the eye). It is important that contact lens wearers periodically be evaluated to make sure that their lenses are still fitting properly, that the cornea and external eye are healthy, and that vision is corrected properly. This involves services and procedures that are not part of a routine vision examination. Because of this, contact lens evaluations are charged an additional fee over and above the cost of a routine examination depending on the specific patient's needs. Contact lens wearers should be seen at least once per year for an evaluation.

I HAVE READ AND UNDERSTAND THIS PATIENT FINANCIAL AGREEMENT. I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS AND TO RECEIVE A COPY OF THIS AGREEMENT AND I ACCEPT THE RESPONSIBILITY OF ITS TERMS.

Patient: _____ **Date of Birth:** _____

_____ _____/_____/_____ _____

Patient/Authorized Signature **Date** **Relationship to patient**