Patient's name: _____ Date of Birth: _____Today's date: _____

InSight Vision Therapy Policies

Financial Policy: We are dedicated to providing the best possible care for you. Understanding your financial responsibilities is an essential part of this. InSight Vision Therapy is not contracted with any insurance companies. Full payment is due at the time of service. If you have vision or medical insurance, we will submit the claim (if allowed) as a courtesy to you, as an out-of-network provider. If the insurance pays for services, we will reimburse you. It is your responsibility to verify insurance coverage for examinations and / or vision therapy. You agree to allow us to release information about your eye care to your insurance company or third party payer. By signing below, you agree to be responsible for payment of all services rendered to you and your dependents.

Signature: _____

Consent for Treatment: Accurate health information is essential for proper care. By signing below, you certify that you have completed the health information forms accurately to the best of your knowledge. It is important to understand that providing incorrect information can be dangerous to your health. It is your responsibility to inform this office of any changes in health status. Signing below authorizes this office to use your (or your dependent's) eye health information to third party payers or health practitioners involved in your care. You authorize this office to perform any treatment that may be indicated.

Signature: _____

Privacy Practices (HIPAA): This office will always take strict precautions to protect your health information. We have privacy practices in place. If you would like a copy of our current privacy practices at any time, they are available at the front desk. The policy explains how this office will use and disclose your protected health information, your privacy rights regarding your protected health information and this office's obligations concerning the use and disclosure of your protected health information. If you have further questions, you may also contact the Secretary of the US Department of Health and Human Services. By signing below, you acknowledge that you have the right to receive and review a copy of this office's Notice of Privacy Practices.

Signature: _____

Please list which people you authorize to discuss your health and/or medical information with this office:

Name	Relationship	Medical information		Billing information	
		Yes	No	Yes	No
		Yes	No	Yes	No
		Yes	No	Yes	No

Photo / Video Release: InSight Vision Therapy may utilize photographs and videos for training and education purposes, on social media and / or presentations. By signing below, you authorize our office to use your photographs / videos. Please indicate which formats you allow, and if symptom / treatment information may be shared. No other personal information will be shared, including your name.

□ Social Media □ Website □ Brochures □ Presentation materials □ Symptom information ok

Signature **only** if you allow sharing of photos/videos: _____