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. Payment in full is due at the time of service. If you have 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 a 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 your responsibility to inform this office of any changes in health status. Signing below authorizes this office to use you (or your dependent's) eye health information to send to third-party payers or health providers 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 a privacy policy in place that 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. A copy of our current privacy practices is available at any time; inquire at the front desk. 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 our 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

Communication with Health Providers: Our optometrist believes that interdisciplinary care is vital to caring for the whole person. Unless otherwise noted, evaluation reports and/or referrals may be sent to providers listed on your account.

□ Yes, I allow that □ No, I do not allow interdisciplinary communication Signature: _____

Communication: Do you authorize our office to send you communications via email? □ Yes □ No

This may include: □ Scheduling info. □ Health questions □ Newsletters

Photo / Video Release: Our office may utilize photographs and videos for training and education purposes, on social media and/or presentations. No personal information will be shared other than symptoms, including the patient's name.

Do you authorize our office to use your photographs/videos? □ Yes □ No

If yes, indicate which formats you allow and if symptom/treatment information may be shared:

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

If the patient is a minor, who has custody? _____