NORTHWEST VISION
THERAPY
ENRICHING LIVES
Specialty Eyecare Group
Kristi Kading, OD, FAAO, FCOVD | Katherine Shen, OD

Optometric Vision Therapy Treatment Plan

Date: Patient Name: DOB:

Treatment for (diagnoses):

Estimated Treatment Length: Units = Sessions

Each Vision Therapy Session includes (see attached for further explanation of codes)

1. *Orthoptics* (92065) is a medical procedure code that may be billed to insurance = $75.00
2. *Visual Information Processing* which is not covered by medical insurance = $100.00

Progress Evaluations

Progress evaluations with the doctor are completed about every 12 sessions (each treatment unit). These are office visits that are billed to medical insurance and are subject to your co-pay, deductible and/or co-insurance.

Equipment Rental $250.00

This is a **one-time** *Equipment Rental Fee* due at the first therapy session. Included is individualized vision therapy software for the patient to use and keep ($150.00 value). The remaining is for upkeep and replacement of instruments and materials borrowed for home therapy practice throughout treatment. Please remember to bring items back after completing activities.

You may purchase additional vision therapy software during your program as recommended by the doctor.

11830 NE 128th St. Suite 1, Kirkland, WA 98034
p. (425) 821.8900 / f. (425) 814.9782

1911 4th Avenue, Seattle, WA 98101
p. (206) 622.4828 / f. (206) 622.8247

Insurance Verification Summary (Tax ID 264078168) for Orthoptics code 92065

Insurance: Primary Name: Policy #: Group#:

Date: Verified by: Reference & Name:

Insurance states: In network / Out of network / Non-covered service

Deductible of _____ apply / does not apply; _____met/met in full

Coverage at _____ % of allowable amount Insurance allowable amount _____ .

Estimated insurance coverage _____ (_____%) = _____.

Co-pay _____ and/or co-insurance of _____ apply / does not apply.

Out of pocket maximum of _____ apply/does not apply; _____ met/met in full

Limitation of sessions? Yes _____ available / No Pre-authorization OR med. necessary letter needed? Yes / No

Insurance renews: Calendar year / Date _____

Payment

Payment is due at or before time of service. We have financing options through Care Credit with no-interest plans available. A signed treatment plan by the financially responsible party is needed by the first therapy session.

In signing this statement I agree to be financially responsible for all charges. I understand that my insurance is not a substitute for payment, and it is my responsibility to pay the total due. The payment is due no later than the time of service. I understand that verification of my insurance coverage is a customer service Northwest Vision Therapy has chosen to do for me and is not a guarantee of payment.

Financially Responsible Party/Guardian _____ (printed name)

Signature _____ Date _____

Attendance Policy

Regular attendance is very important for success of the vision therapy program. Please let us know 48 ***hours*** before scheduled session if it will be missed. This allows us to offer the open slot to other patients who need to schedule make-up sessions. We understand that unforeseen circumstances can prevent you from attending a regularly scheduled session, which is why we have a "**Three Strikes"** policy.

"**Three Strikes"** policy: A strike will apply for all absences that are not scheduled for a make-up at the time of cancellation. After three strikes, therapy will be terminated.

If a patient is absent for a scheduled session, a make-up session needs to be made within two weeks and before the next progress evaluation. We will do everything we can to accommodate your schedule; however, please understand that available appointments are limited to availability and may be at inconvenient times. Patient may see another therapist for a make-up.

If you know in advance of multiple appointments that will be missed (vacation, etc.) please communicate with the manager as soon as possible. Make-ups can be made up in advance.

In signing this statement I agree that I have read and understand the Attendance policy.

Patient Name _____

Financially Responsible Party/Guardian _____ (printed name)

Signature _____ Date _____