Visual Performance Center

8200 Whitesburg Drive South, Suite B, Huntsville, AL 35802
256-880-0133

WELCOME TO OUR OFFICE

Patients Name _____DOB _____Today's Date_____

Address_____ City_____ State _____Zip_____

Home Phone _____ Sex: M____F_____ Referring Doctor_____

School_____ Grade_____ Teacher_____

Parent or Guardian _____Relationship_____

Cell Phone Contacts: Mother _____Father _____Other_____

Email _____

Occupation_____ Place of Employment_____

Business Address _____ Work Phone _____

Guarantor's Social Security # _____

Payment in full is due at the first therapy session. If you elect to pay using the monthly plan, the first payment is due at the first therapy session. Each monthly payment is due at 30 days, 60 days, and 90 days after beginning therapy.

I agree to the above terms of payment. Should this account become delinquent for any reason, I agree to pay any reasonable fees for collection including attorney's fees.

Signature _____*Date* _____

I understand that vision therapy is designed to improve visual skills and make it easier for my child to concentrate and attend to what he is learning. It can make reading easier and more comfortable, eliminate eyestrain, discomfort, loss of place, reversals and allow the child to copy more quickly and neatly. I also understand that vision therapy DOES NOT directly improve reading, math or spelling nor can it guarantee better grades in school. It does make the child better able to benefit from standard or special education.

I also understand that up to 30 minutes of daily at home exercises are required for success in this program. Neglect in at home exercises can cause slower progress and improvement that is only temporary and not lasting. However, diligent work can minimize the number of sessions necessary to reach the therapy goals.

*Signature*_____*Date*_____

I UNDERSTAND THAT THERE WILL BE A $40 NO-SHOW FEE ADDED TO MY ACCOUNT FOR MISSED APPOINTMENTS WITHOUT PRIOR NOTICE.

*Signature*_____ *Date* _____