Vision Source Eyecare Vision Therapy (VT) Policies

Initial Testing and Placement in VT

Your initial appointment is for a comprehensive examination. During this exam, we will gather the data and information necessary to determine if VT is needed. The comprehensive exam takes approximately 30 minutes and costs $104.

Extensive testing and data-gathering will then be scheduled and completed by our vision therapist, including a visual-perceptual evaluation and reading assessment if applicable. This functional vision evaluation process typically takes two one-hours to complete at a cost of $250, and is payable at the time of the appointment. Approximately 2 weeks after the completion of all testing and assessments, you will be provided with a detailed report that summarizes the results and proposed treatment. If the patient is a student, a copy of this report should be provided to his/her school office and teacher(s).

Paying for Vision Therapy

- **All fees are the responsibility of the parent, patient, or guardian and are due at the time of service.**
- **Vision Source Eyecare does not file insurance for VT sessions.** If you have medical insurance, we are happy to provide you with the necessary codes and an itemized receipt of your payment should you wish to submit a claim to your medical insurance company yourself.
- Vision Therapy fees are structured in the following manner:
    - Most patients are able to complete their vision therapy treatment in 24 - 48 weekly sessions. If full payment of the recommended number of sessions is made up front, you may be eligible for a 10% discount.
    - If additional sessions are required, the cost will be adjusted at that time. The most common reason for additional sessions is inconsistency or noncompliance with VT at-home exercises.
    - The reason that our office advocates paying in full prior to treatment is we believe that in order to help the patient achieve his/her full potential, there must be a firm commitment made up front. To receive the maximum benefits of vision therapy, the recommended treatment time must be completed. Discontinuing treatment prior to completion is not fair to the patient or to the reputation of our office.
    - If you are unable to pay in full prior to starting treatment, you may choose to pay one month at a time or pay for each day's session when checking in with our front desk upon arrival.
    - Care Credit information is available online and in our waiting area. If approved, this service may enable you to stretch payments out interest free over a period of time determined by Care Credit.

Cancelled and Missed Appointments

Please understand that VT programs are individualized and time is spent planning and preparing the patient's therapy, as well as the time reserved for your in-office visits. Please notify us as soon as possible if you are unable to make your appointment. For your convenience, you may text 816-398-7229 to reach the vision therapist. Cancelling an appointment less than 24 hours prior to the appointment may result in a $50 cancellation fee. We apologize for any inconvenience, but our schedule is limited and your appointment slot is reserved for you.

Progress Evaluations

Progress evaluations will be scheduled periodically during treatment. The purpose of this evaluation is for the doctor to track your progress and to modify your vision therapy program as needed. If a patient is ahead or behind schedule, the number of sessions recommended will be modified accordingly.

Home Therapy (VT "Homework")

The doctor and vision therapist will estimate how many sessions are necessary based on the severity of the patient's condition. This estimate will vary depending on your consistency and compliance with home therapy. You are expected to do home exercises ***at least*** 5 days each week in order to be successful with this program, to finish in the estimated number of sessions, and to maximize results. Fees for home therapy materials may apply. The last 5 minutes of each 45 minute VT session will be used to explain home therapy activities to the patient and/or parent.

Patient Name _____ Estimated number of sessions _____

Parent/Guardian or Patient signature _____