Vision Forward Association
Children's Program
Service Agreement

We are excited to partner with your family and child. To ensure the highest level of care for your child, we have established the following expections.

Services to be provided:

□ Vision evaluation
□ Orientation and mobility evaluation
□ Ongoing vision services
□ Ongoing orientation and mobility services
□ Music therapy
□ Physical therapy
□ Occupational therapy
□ Speech and language therapy
□ Other:_____

Vision Forward agrees to:

- Provide a written comprehensive evaluation after your initial visit.
- Provide ongoing medically-based therapy services or vision consultation services at a mutually agreed upon frequency, time and location.
- Ensure that you understand your child's diagnosis and encourage your involvement in establishing a home program.
- With consent, share information with other professionals that may be working with your child.
- Comply with federal regulations implementing the Health Insurance and Accountability Act of 1996 (HIPAA) to the extent that those regulations apply.

Client Agrees to (initial):

_____ Pay any balance due within 30 days of receipt of statement.
_____Arrive 5-10 minutes early for all appointments, with the appropriate equipment (wheelchair, feeding supplies, AFOs, etc.)
_____Comply with the no show / cancellation policy below.
_____Stay and participate with your child during the evaluation and follow up sessions.

No Show / Cancellation Policy

We understand that it may be necessary to cancel an appointment due to unforeseen circumstances. Please call your provider's mobile number or (414) 615-0160 to cancel an appointment. Please provide at least 24 hours advance notice and the reason for the cancellation. While advance notice of appointment cancellations are expected and appreciated, excessive cancellations are disruptive to your child's progress and to the professional's schedule. **More than two cancellations or more than one no call, no show for an appointment in a 30-day period may result in discharge of services.**

Payment for Services:

Physical / Occupational / Speech therapy services will be billed to insurance. Please see Assignment of Insurance document for more information.

Hourly rate for services not covered by insurance: _____ per hour.

Acknowledgement:

I have read and fully understand and with comply with this agreement.

Child's Name: _____

Signature of parent/legal guardian: _____ Date: _____