*Developing Children's Vision and Enhancing Adult Performance*

**Jennifer S. Simonson, OD, FCOVD**
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PATIENT'S FULL LEGAL NAME: _____ SEX: M F

STREET ADDRESS: _____ DATE OF BIRTH: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ ALTERNATE PHONE: _____

EMPLOYER: _____ JOB TITLE_____

IF MINOR, SCHOOL NAME: _____ TEACHER _____

**GUARANTOR INFORMATION (PERSON RESPOSIBLE FOR BILL)**

GUARANTOR'S FULL NAME: _____

RELATIONSHIP TO PATIENT: _____ DATE OF BIRTH: _____

ADDRESS: same as above different than patient:_____

PHONE NUMBER: _____ E-MAIL ADDRESS: _____
(Only used for office communication)

**REFERRED BY:** _____

**STATEMENT OF FINANCIAL RESPONSIBILITY:**

Boulder Valley Vision Therapy Center does not contract with insurance companies as a provider. Patients who carry any form of medical insurance should know that all services furnished are charged directly to the patient. Payment is due at the time of service, therefore, we cannot render services on the assumption that your charges will be paid for by your insurance company. We will make every effort to ensure that you have the information necessary to seek reimbursement from your medical plan. I, THE UNDERSIGNED, HAVE READ THE ABOVE AND UNDERSTAND THAT ALL CHARGES INCURRED BY MYSELF OR MY DEPENDENTS FOR SERVICES RENDERED BY BOULDER VALLEY VISION THERAPY CENTER ARE MY FINANCIAL RESPONSIBILITY.

SIGNED: _____ DATE: _____

**NOTICE OF DISCLAIMER**

The doctors of Boulder Valley Vision Therapy, P.C. provide to their patients functional vision testing and therapy services to correct visual-motor and/or perceptual-cognitive deficiencies. The patient is responsible for obtaining separate examinations and evaluations of the health of the eyes and treatment of any and all diseases and conditions of the patient's eyes from the patient's primary eye care provider, as these services are not provided at this referral center. I, THE UNDERSIGNED, UNDERSTAND THAT BOULDER VALLEY VISION THERAPY CENTER IS NOT PROVIDING AN EYE HEALTH EXAMINATION OR EVALUATION OF EYE DISEASE. I WILL SEEK THIS CARE FROM MY PRIMARY EYE CARE PROVIDER.

SIGNED: _____ DATE: _____