WELCOME to *Vision Sensory Integration Institute (VSII)*!

To better assist you please provide us with the following information:

PATIENT INFORMATION:		
Name:	Birth date: / /	SS#: - -
Address:		
City:	State:	Zip code:
Home Phone:	Work phone:	
Cell phone:	Gender: M ____F____	
Email address:	Occupation:	

ACCOUNT responsible:	SAME AS ABOVE:	
Name:	Birth date: / /	SS#: - -
Address:		
City:	State:	Zip code:
Home Phone:	Work phone:	
Cell phone:	Gender: M ____F____	
Email address:		

ACKNOWLEDGEMENT OF RECEIPTS OF HIPAA NOTICE PRIVACY PRACTICES:	
I have received a copy of the privacy practices of VSII. I also affirm that all information supplied to VSII is complete and accurate to the best of my knowledge.	
Signature:	**Date**:

Phone: 630-429-7553
19 E. Schaumburg Rd. Suite 100

http://vsiionline.org/

Fax: 847-891-8045
Schaumburg, IL 60194

READ CAREFULLY: **FINANCIAL POLICY INFORMATION TERMS & CONDITIONS:**

- As the patient or person responsible you are required to pay all fees at the time of receiving your services.
- Vision & Sensory Integration Institute is not within network or accepts any insurance. If you choose to bill your insurance we can provide you with superbills however, it is you're responsibility to bill and deal with your own insurance for reimbursement.
- Any ACCOUNT OVER 45 DAYS OLD that are not brought current, will be forwarded to a collection agency. I In addition to the principle owed I agree to pay 33.33% of the unpaid balance as a collection fee if my account is turned over to a collection agency. I further agree to pay reasonable attorney fees and court cost arising of any litigation concerning the collection of this account.

BY SIGNING BELOW, YOU acknowledge to HAVE RECEIVED AND UNDERSTAND THIS NOTICE AND ACCEPT THE TERMS AND CONDITIONS as LISTED ABOVE.

________________________________ ________________

SIGNATURE DATE

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