Starting a Vision Therapy Service: A Checklist

The operational and clinical decisions to make before your first vision therapy patient.

The operational decisions behind a vision therapy service need to be made before the first patient, not improvised after. This checklist walks through them in a reasonable order. For the full reasoning behind each decision, see the Bringing Vision Therapy Into Your Practice guide.

1. Practice Fit

- Confirmed a meaningful patient base exists: school-age children, students, or heavy near-work adults
- Identified where referral relationships need to be built if the existing patient base is thin
- Honestly assessed whether this is a service you want to build patiently over months, not a fast revenue line

2. Space and Scheduling

- Dedicated therapy room identified — not a shared pretest area
- Consistent weekly time blocks set aside for recurring sessions
- Scheduling system decided: how therapy sessions get booked, rescheduled, and tracked separately from routine exams

3. Staffing

- Decided who will deliver weekly sessions: yourself initially, or a therapist being trained
- If training a therapist: candidate selected for temperament first, clinical aptitude second
- Supervision plan set for the first two to three months — new therapists shouldn't work unsupervised until they've shown competence troubleshooting activities, not just running them

4. Scope

- Starting scope defined: convergence insufficiency, accommodative insufficiency/infacility as the core starting conditions
- Referral-out list defined: strabismus, complex amblyopia, acquired brain injury, post-concussive vision problems, and anything that doesn't make clinical sense
- A developmental optometrist identified in your area for referring complex cases

5. Diagnostic Protocol

- Full binocular vision workup protocol defined — not just NPC and cover test

- Standard testing battery decided for each condition you plan to treat
- Symptom questionnaire (such as the CISS) built into the intake process

6. Program Structure

- Defined phases and progression criteria established, not a week-to-week improvised plan
- A plan in place for what happens when a case plateaus or isn't improving
- Home reinforcement protocol built to be specific, checked regularly, and not excessively long

7. Case Presentation

- Standard language ready for explaining the diagnosis, why therapy works, and what it requires
- Realistic timeline expectations set from day one — symptom relief early, meaningful resolution typically takes five to six months
- A plan for handling the "but they passed the school screening" objection

8. Operations

- Pricing and payment structure finalized
- Insurance and billing approach decided
- Progress evaluation schedule and format set

9. Marketing

- A recurring, scheduled outreach plan built — weekly, monthly, and quarterly, not a single launch campaign
- Referral messaging prepared for each professional type you plan to reach (see the Referral Conversation Guide)
- A habit established of mentioning VT to every patient, not just apparent candidates

10. Training Pathway

- Formal training path chosen: OEPF or OPSIS for a full start-to-finish curriculum
- A mentor relationship identified for troubleshooting stalled cases
- A plan in place for the doctor to personally try every activity before assigning it to a patient or therapist