DOWNTOWN VISION CENTRE

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NEURO-OPTOMETRIC TRAINING PATIENT FINANCIAL RESPONSIBILTY FORM

Patient Name: _____ **Scheduled for:** _____ **/** _____ **/** _____ @ _____ **pm**

Vision Therapy is sometimes PARTIALLY covered by insurance plans. We ask that you check on your insurance benefits prior to vision therapy so that there are no surprises with payment or reimbursement.
Please fill out this form and return it signed before we commence Vision Therapy services.

Ask your insurance the following questions and document the answers:

Is Dr. Linda Medeski an in-network provider with my specific insurance plan? ___

Is out patient neuro-rehabilitation a covered service under my plan? ___

Are theses 3 procedure codes covered under my plan:
92065: Orthoptics $90
99213: Intermediate medical exam $137
92499: Visual Information Processing $66

With diagnosis codes:
__ __ __.__ __:_____

__ __ __.__ __:_____

Are these procedures covered when performed by an O.D.? ___

Is prior authorization required for any of the above procedures? ___

Will these procedures be applied to my deductible? ___
If yes: My deductible is: $_____
Have I met my deductible: _____

Name of the insurance representative that provided the above information: _____

We will bill your PRIMARY insurance as a courtesy. If your insurance refutes payment or only partially covers the charge, the remaining balance will be your responsibility. It is within your insurance companies' rights to deny coverage even after written and documented prior verbal authorization. Although uncommon, should this happen, you will be financially responsible for your sessions.

Here's what to expect for costs:

Training Sessions:
Your Neuro-Optometric Rehab Therapy sessions will be 45-55 minutes long, once a week. We schedule our sessions in "Blocks," one block is 10 weeks.
ONE BLOCK=10 sessions

Sessions can range from $156.00-$293.00

Equipment Fee: $50.00

Progress Evaluation: $297-$472
(Performed at the end of each block needed and may require a repeat of developmental testing)

No Show Fee: $75.00
(For no-show or non-emergency cancelled appointments within 48 hours - NOT covered by insurance)

Please mark an option that applies:

☐ **Insurance coverage:**
At this time, I believe that I am still covered by insurance. I understand that I will be responsible for any amount due during the entire length of the program, if for some reason, including but not limited to prior-authorization obtained, prior-authorization waived or any deductibles not met for the year. Insurance benefits, as quoted by your individual insurance company, and in turn quoted to you by our office, are an ESTIMATE of payment only. I understand that my insurance carrier may pay less than the actual bill for services. I am also aware that I am responsible for any non-covered service(s) or material(s) that I request.

☐ **No Insurance:**
I will pay in full at the time of service or use CareCredit.

X_____ _____ _____ **/** _____ **/** _____
[Signature of Parent or Guardian] **[Relationship to Patient]** **[Date]**