DOWNTOWN VISION CENTRE

912 Main Street • Vancouver, Washington 98660
360.694.6541 Phone • 360.696.2578 Fax.

VISION THERAPY EVALUATION 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.

Medical Insurance:_____
Insurance I.D. #:_____

Ask your insurance the following questions and document the answers:
Is Dr. Linda Medeski an in-network provider with my specific plan? ___

Your diagnosis code is:

__ __ __. __ __ :_____

__ __ __. __ __ :_____

The Vision Therapy evaluation is billed with the below possible procedure codes:

92060: Sensorimotor Examination $127
99203: Intermediate Medical Exam $203
99354: Prolonged Face to Face time $183
96111: Developmental testing: extended $208
96110: Developmental testing: limited $25
92499: Vision Therapy Evaluation $170

Ask them if prior authorization is 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: _____
If yes: Is there a coinsurance? _____
If yes: My coinsurance is? _____

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 are given. Although uncommon, should this happen, you will be financially responsible for your sessions.

Here's what to expect for costs:

Initial Evaluation: $393.00-$681.00

Developmental Testing: $208.00-$416.00

Conference: $50.00
Review of evaluation results and recommendations

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, Vision Therapy charges are denied, 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.

Developmental Testing: Your insurance payment for this type of testing may be dependent on which specialties are contracted. We would like you to know up front that if your insurance pays for the testing and then upon an audit, we may be required to return the payment. In that case, we would need to look to you for payment.

☐ **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]**