

DOWNTOWN VISION CENTRE

912 Main Street • Vancouver, Washington 98660

360.694.6541 Phone • 360.696.2578 Fax

VISION THERAPY TRAINING PATIENT FINANCIAL RESPONSIBILITY 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? ____

Is Vision Therapy a covered service under my plan? ____

Your diagnosis code is:

____. ____. ____:

____. ____. ____:

Vision Therapy is billed with 2 main procedure codes:

92065: Orthoptics \$90.00

92499: Visual Information Processing \$66.00

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 refuses 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 Vision 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-\$206.00
(\$90.00 billed to insurance if allowed, the remainder is your responsibility)

Equipment Fee: \$50.00

Progress Evaluation: \$393.00-\$681.00

Developmental Testing: \$208.00-\$376.00
(Performed at the end of each block and usually requires 2 visits. The second visit is needed for any developmental testing that needs to be repeated)

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]