Austin Pediatric Ophthalmology & Strabismus

Patient Information Update

Patient's Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Primary Phone: _____ Primary Care Doctor: _____

Allergies:

_____

Current Medications:

_____

List ant medical changes since prior visit:

_____

Insurance Company Name: _____ □ New □ Same

Insured's Name: _____

Policy Number: _____

I _____, the undersigned certify that myself, or my dependent have insurance coverage with the above named insurance company and assign directly to Megyn L. Busse MD all insurance benefit payments. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I understand that all outstanding accounts must be settled within 80 days of the first billing statement or there will be a $25 per month administrative late fee. The fee for refraction or motility exams denied by your insurance will be reduced to $50.00 each. I authorize the use of this signature on all insurance submissions.

I certify that the information on these forms is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as deemed necessary in the diagnosis and/or treatment of myself, or my dependents.

Guarantor Signature: _____ Date: _____

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Important Patient Information

Refraction Policy: 92015

What is a refraction exam?
This test is a determination of an eye's refractive error and the best corrective lenses to be prescribed. Doctors agree that this test is a necessary element of most visits, and it is used to create prescriptions for glasses and/or contact lenses, and/or to evaluate possible changes in vision due to medical conditions. This is essential in order to determine if a decrease in vision is due to only a need for glasses, which is easy to correct, or if another medical reason might be keeping the eye from seeing.

Sensorimotor Examination: 92060

What is a sensory motor exam?
A sensory motor examination detects, assesses, monitors, and/or manages strabismic conditions. This is an expanded examination which requires additional time, effort, and expertise in measurement of the ocular deviation in various fields of gaze, different distances, and/or with and without optical correction. Doctors agree that information from the sensorimotor examination is used to plan medical, optical, and surgical treatments for these conditions and can have important visual, developmental, and/or systemic implications.

Does my insurance plan pay for this test/exam?

Your insurance may consider these procedures excluded from your benefits and/or a non-covered benefit.

What do you charge for these exams?

In the event that your insurance does not cover the **92015** or **92060** the cost to you will be **$50.00 per test/exam performed.**

I have read and understand the above, and I have had the opportunity to ask questions

_____
Patient Name

_____ _____
I agree to have the following test/exam performed Date

_____
I decline for the following test/exam to be performed
and decline a glasses and/or contact prescription

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Patient Financial Responsibility Agreement

As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. Not all services are covered in all insurance contracts. In addition, you should be sure that your physician is listed as a participating provider by your insurance company. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges.

In the event that your insurance is not valid or your coverage was terminated at the time the services are rendered, you will be solely responsible for the full amount of your office visit and/or any procedures rendered.

In addition, if your insurance plan determines a service or product to be "not covered,"you will be responsible for the complete charge of such services.

I agree to be responsible for the payment of ALL unpaid services rendered on my behalf or my dependents.

_____ _____

Patient/Guardian Signature Date

Austin Pediatric Ophthalmology & Strabismus

At Austin Pediatric Ophthalmology, we are required to implement the Meaningful use initiatives. As a result, we are collecting the government-mandated information below. The purpose of Meaningful Use is to ultimately improve patient care and lower health care costs.

The information you provide will be used for reporting purposes only.

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Patient or Parent Email: _____

Preferred Pharmacy

Pharmacy Name: _____

Pharmacy Address: _____

Parent Signature: _____