Megyn L. Busse, MD 4700 Seton Center Parkway Austin, Texas 78759 P: 512-345-3595 F: 512-345-7618

Patient Information Update

Patient's Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Primary Phone: _____ Secondary Phone: _____

Emergency Contact: _____ PCP: _____

Allergies:

_____

Current Medications:

_____

List any medical changes from prior visit:

_____

Insurance Company Name: _____ new ( ) same ( )

Insured's Name: _____

Policy Number: _____

Phone: _____

Social Security #: _____

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, M.D. 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 30 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's Signature: _____ Date: _____

Austin Pediatric Ophthalmology and Strabismus PA

Megyn L Busse, MD
4700 Seton Center Pkwy
Suite 150
Austin, TX 78759

Important Patient Information:

Refraction Policy: 92015

What is a refraction?
This test is a determination of an eye's refractive error and the best corrective lenses to be prescribed. The 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 clearly.

Sensorimotor Examination: 92060

What is a Sensory Motor Exam?
A sensorimotor 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 procedure's excluded from your benefits and/or a non-covered benefit.

What do you charge for these?
In the event that your insurance does not cover the **92015 or the 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 perform

_____
Date

_____
I Decline for the following test/exam to be perform

AUSTIN PEDIATRIC OPTHALMOLOGY AND STRABISMUS PA
MEGYN L BUSSE, M.D

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 you're insurance plan determines a service or procedure 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, including any fees for collection service needed.

_____ _____

Patient/Guardian Signature Date

Austin Pediatric Ophthalmology

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 _____**Patient DOB**_____

Patient or Parent Email _____

Preferred Pharmacy

Pharmacy Name_____

Pharmacy Address_____

Parent Signature_____