Edmonds & Associates LLC

dba Edmonds Eye Associates, Great Valley Eye Associates

3300 Township Line Rd.
Drexel Hill, PA 19026
610-449-2540

840 Walnut St. Suite 1010
Philadelphia, PA 19107
215-928-3450

623 Swedesford Road
Malvernr, PA 19355
610-644-9300

600 Evergreen Drive Suite 201
Glen Mills, PA 19342
610-449-2623

401 Horsham Road
Horsham, PA 19044
610-449-2623

OFFICE POLICIES:

Scheduling: We will make a courtesy call or text or email to remind you of your appointment. We understand that there will be circumstances that may require you to cancel your appointment. We consider any cancellations made after 6 AM of the day of your appointment a "short notice" cancellation. A "no show" is any appointment not kept without first informing the office of your inability to keep your appointment. The management reserves the option of charging your account a fee of $10.00 for each short notice or no show. The office makes every attempt to run on time. Many of our patients have significant medical problems and may require extra time to manage. Often however, scheduling problems arise from the tardiness of patients arriving for care. Therefore, patients that arrive late but within 15 minutes of the scheduled appointment may be worked into the schedule later in the day. Patients that arrive beyond 15 minutes may have to reschedule. By providing your cell phone number, you grant us the right to send you texts for scheduling purposes, recall, and reviews.

Insurance: INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. We will inform you if we are a party to your insurance contract and will handle your claim according to our agreement with the company. We only file insurance claims as a courtesy to our patients. An insurance claim will be completed if we have your correct referrals and you furnish all the information that your plan requires. Otherwise, you are responsible for the payment of all charges at the time of service. All insurance issues must be resolved prior to any services. The office will not submit or accept insurance policies or coverage after the services are provided. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered services, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary.

Non Covered Services: Some of the services that we provide are NOT COVERED by your Insurance. For example, a refraction, the test of different lenses for vision correction is NOT covered by Medicare and many Medical Insurances and must be paid for at the time of service. Non Covered Ophthalmic materials, Contact Lenses, Glasses and Low Vision Aids, require a 50% down payment before the order can be placed. The balance in full is due at time of dispensing.

Billing: Please settle your account at the time of service. Past due bills beyond 30 days carry a 2% interest charge per month up to the maximum allowed under Pennsylvania Law.

HOW WILL YOU SETTLE YOUR ACCOUNT TODAY?

____CHECK _____CASH _____CREDIT CARD

Returns: All material purchases are only subject to a return at the ordering doctor's discretion. Used, opened, or damaged materials will not be refunded. All materials have up to a 50% restocking fee.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT I AGREE WITH AND WILL ABIDE BY ALL POLICIES.

Date: _____ Signature: _____

HIPAA policy - I CERTIFY THAT I HAVE READ AND UNDERSTAND THE HIPPA POLICY ON THE FOLLOWING PAGES

Date: _____ Signature: _____

Note 2 signatures are required to complete this form

rev 2020

Therapy Agreement Edmonds & Associates, LLC

We will submit bills for payment for our services to any third-party agents involved with your medical condition. This includes Workman's Compensation, Auto insurance or Health insurance. These contracts and agents, however, vary greatly and coverage is not often clear until after a claim is filed. The contract is between you and your insurance company. We file claims on your behalf. We need your participation with the process as you are the covered party in the contract with the insurance or third-party carrier. Please check and follow-up with your insurance company to see if they are covering your care and report to our team with any required information.

Some insurances may have a time limit or dollar limit that can stop the coverage in the middle of the treatment course and report that your benefits are exhausted. If we are aware of this, we can help you decide on a treatment plan that will be paid by you directly.

If we are submitting any visit to your Auto insurance, it is your responsibility to give us your claim number, policy number, adjuster's name and phone number BEFORE your visit, otherwise you may become responsible for the visit.

If we are submitting through Workman's compensation, it is your responsibility to give us all pertinent information related to your case required for us to bill for the service appropriately. This information includes claim number, insurance company name and address as well as a contact name and number. This is required at the time of the first visit.

Your coverage will depend on your insurance company or the third-party agency as well as your specific policy. We can NOT guarantee that your services will be paid in full by your carrier. You should check with your company and stay current with your balance.

If your insurance carrier requires an insurance referral to see a specialist, please obtain it from your primary physician. It is required prior to your visit. We will accept insurance payments for any services that are covered by your carrier. **However, services that are not covered will ultimately fall back to you for payment. You are also responsible for any deductibles and copayments.** If you have a specialist co-payment, it will be collected at the time of the visit. Balances are due upon receipt of bill.

The evaluation normally consists of the following codes:
99243 Office consultation
92060 Sensorimotor Exam
92015 Refraction

The therapies normally consist of the following codes:
99212, 99213, 99214 Medical Office Services
92065 Orthoptic Training OR
97530-GP Therapeutic Activities for Medicare patients

I acknowledge that this agreement has been explained to me and that I have had the opportunity to ask questions about the agreement and services provided. I agree to pay for services transferred to me from my insurance company and any co insurance, deductibles, and non-covered services.

Responsible party (parent if minor) _____

Date_____

Acquired Brain Injury Data Base:
Name: _____ DOB: _____

Referring Provider _____

Right or left handed? _____

Nature of brain injury:
Concussion: Y/N
If yes: Date of most recent _____ Number in last five years? _____

***If known, please list dates of previous concussions*:**

1) _____ 2) _____ 3) _____ 4) _____ 5) _____

Stroke: Y/N If yes: date _____

Sports injury Y/N
If yes: Date _____ Sport _____

Motor Vehicle Accident Y/N
If yes, Date _____ State where accident occurred _____

Fall Y/ N If yes: Date of fall _____

Neurological Problem (please describe)
_____ Date of onset _____

Other lines of therapy: Please check all that apply

Vestibular _____ Provider _____
Cognitive _____ Provider _____
Speech and Language _____ Provider _____
Physical Therapy _____ Provider _____
Occupational Therapy _____ Provider _____
Mental Health Counseling _____ Provider _____

Vision Symptoms: Please check all that apply

Headaches _____ Blurred Vision _____ Double Vision _____ Trouble with screen time _____

Dizziness _____ Disorientation _____ Photo sensitivity _____ Problems reading _____