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Information for Traumatic Head Injury Clients

Updated March 2012

You have been scheduled to see Dr. Hutchins for a visual examination. She will evaluate your visual skills as related to your brain injury. The following information will help you to know what to expect with regard to insurance billing versus self payment. Please note: ***We do not accept clients unless this form is signed and you agree to all conditions.*** Please call our office with any questions. Traumatic brain injury clients fall into several categories: Non-automobile Accident, Automobile accident with medical payments coverage, or Automobile Accident with no medical payments coverage.

1. ***If your accident was not automobile related or you do not have medical payments coverage on your autombile policy, you are personally responsible for your bill. You will be expected to pay at the time of the exam. The initial appointment fee will range from $150 to $300.*** The exact amount depends on the tests performed and the number of visits required to complete your evaluation. We do understand that many people have financial constraints and are not able to pay in full at the time of service. We are willing to work with you and arrange a payment plan. If it is determined that you need vision therapy, then you will be responsible for payment. If you have major medical insurance, we will assist you in determining whether you have coverage for vision therapy. Some insurance companies cover a portion of vision therapy. We will supply you with a paid receipt that can be submitted to your health insurance for reimbursement.
2. If you have medical payments coverage through your automobile insurance our office policy is as follows:
   - ***You are responsible*** for providing us with complete information for filing your claim. We will submit your claim for the initial evaluation. ***You will be responsible*** for following up with your insurance company regarding this claim.
   - Some insurance companies only cover what they deem to be ‘reasonable and customary’. ***You are responsible*** for paying the disallowed amount.

You are ultimately responsible for your bill. We will assist you in filing your insurance claims and providing information to your attorney.

I have read, understand, and agree to the above office policies:

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Patient (please print) Date

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Signature (Parent or Guardian if a minor) Relationship to Parent

Patient's Name ________________________________ Today's Date ___________

Responsible Party ____

Relationship to patient ____

Date of Accident ____

Automobile Insurance ____

Claim Number ____

Name of Insured ____

Claim Adjuster ____

Medical Payments Coverage Remaining _______________________________________

Mailing Address ____

____

____

Auto Insurance Phone # ____

Fax # ____

Email address ____

Attorney's Name ____

Paralegal ____

Address ____

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Attorney's Phone # ____

Fax # ____