

Information for Traumatic Brain Injury Clients
Office of Rebecca E. Hutchins O.D., F.C.O.V.D. and Associates
6800 North 79th Street, Suite 101
Niwot, CO 80503
Phone: 303.652.0505 Fax: 303.652.0606
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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 automobile 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 \$195 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:

Patient (please print)

Date

Signature (Parent or Guardian if a minor)

Relationship to Patient

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 _____

Attorney's Phone # _____

Fax # _____