❏ **Wallerich Eye Care – St. Paul (Midway)**
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## Information for Traumatic Brain Injury Clients

You have been scheduled to see Dr. Michael Wallerich for a neuro-optometric evaluation. He will evaluate your visual skills as related to your brain injury. The following information will help you to understand or to know what to expect in 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. If you have any questions, please call our office and speak with the clinical manager. Traumatic brain injury clients fall into several categories:

- **Non-Automobile Accident** (medical insurance or self-pay)
- **Automobile accident with medical payment coverage** (requires authorization from auto insurance)
- **Automobile accident with no medical payment coverage** (credit card on file)
    a. Personal Injury Protection (PIP) – may cover all/partial/none of your medical payments pending your insurance provider's review of records or maximum coverage of medical expenses
    b. Signing this form, you agree to pay for all services unpaid, as professional services rendered are non-negotiable /non-refundable.

If your accident was a **non-automobile accident/injury**, it will be billed to your medical insurance carrier (excludes worker's compensation claims) or is expected to be self-pay. This is a medical eye visit, which will have copays, deductible costs, co-insurance and/or other associated costs with special testing (pending medical necessity/documentation purposes). Wallerich Eye Care is able to give estimates related to the associated costs; however, the nature of the problem, severity and complexity does not allow for exact costs for the initial visit ($300-$550). Initial evaluations take approximately 1 hour and 15 minutes; however, if more time or additional follow-ups are needed, it will be discussed at the time of your initial appointment.

On occasion, medical policies may not cover certain procedures or necessary items during your evaluation, you will be responsible for those copays/billed amounts. In addition, Dr. Wallerich may recommend neuro-optometric rehabilitation (vision therapy) as a treatment to improve your eye and vision outcome. Those services may or may not be covered by your insurance provider. We will assist you in determining whether your insurance may partially/fully cover the cost of your therapy visits. 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 to arrange a payment plan.

If you have **automobile accident with medical payment coverage**, 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 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 for whatever portion is not covered or denied by your insurance carrier (automobile or medical insurance for non-covered services). We will assist you in filing your insurance claims and providing information to your attorney (with a medical release formed signed in office).

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**: _____

**Responsible Party**: _____

**Relationship to Patient**: _____

**Date of Accident**: _____

**Automobile Insurance**: _____

**Claim Number**: _____

**Name of Insured**: _____

**Claim Adjuster**: _____

**Medical Payments Coverage Remaining**: □ Yes or □ No

**Mailing Address**: _____

**City**: _____ **State**: _____ **Zip**: _____

**Auto Insurance Phone #**: _____ **Fax**: _____

**Email Address**: _____

**Attorney's Name**: _____

**Paralegal**: _____

**Mailing Address**: _____

**City**: _____ **State**: _____ **Zip**: _____

**Attorney's Phone #:** _____ **Fax**: _____