Edmonds & Associates LLC

dba Edmonds Eye Associates, Great Valley Eye Associates

3300 Township Line Rd.	840 Walnut St. Suite 1010	623 Swedesford Corporate Ctr,	600 Evergreen Drive Suite 201
Drexel Hill, PA 19026	Philadelphia, PA 19107	Frazer, PA 19355	Glen Mills, PA 19342
610-449-2540	215-928-3450	610-644-9300	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. There is a 5% charge for all non-insurance billing. 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

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

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 _____
Referring Provider _____

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 _____

Wills Eye Hospital
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840 Walnut Street
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