Therapy Agreement

Edmonds & Associates, LLC

dba Edmonds Eye Associates, Great Valley Eye Associates

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:
92004 Comprehensive medical eye evaluation
92250 Fundus Photography
92060 Sensorimotor Exam
92015 Refraction

The therapies normally consist of <u>one</u> medical office code **and** <u>one or more</u> therapy codes

Medical office code depending on complexity:
99212 or 99213 or 99214

Therapy code:
92065 Orthoptic Training or **97530-GP** Therapeutic Activities

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.

Signature_____ 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 _____

Office Policies

Edmonds & Associates, LLC

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Scheduling: We will make a courtesy call, 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 payment before the order can be placed.

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.

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.

Signature: _____Date: _____

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

Signature: _____Date: _____

Note 2 signatures are required to complete this form

rev 2023

Notice of Privacy Practices Edmonds Eye Associates LLC

Effective Date of this Notice: May 1, 2018

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can file a complaint if you feel we have violated your rights by contacting Susan Edmonds at 215-928-3450
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as: Preventing disease / Helping with product recalls / Reporting adverse reactions to medications /Reporting suspected abuse, neglect, or domestic violence and preventing or reducing a serious threat to anyone's health or safety

Do research- We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests -We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, or we can mail a copy to you.