Murray Vision Source

BILLING AND FINANCIAL POLICIES:

Insurance Authorization and Assignment: I request that payment of authorized private insurance company benefits, Medicare and Medicaid services or other applicable benefits be paid on my behalf to Dr. Murray of Murray Vision Source (MVS) for any furnished services. I authorize MVS to release any medical or other information about me to any private insurance company, Medicare and Medicaid or other company and its agents, which might provide coverage to me.

All Services are the Responsibility of the Patient: MVS with gladly bill my primary insurance. I understand that insurance benefits must be determined prior to my exam and that eligibility verification does not guarantee coverage once the claim is filed. **If I become aware of insurance coverage after services have been rendered, I agree to personally submit the claim to my insurance company for reimbursement**. I understand that when my insurance company requires a referral from my primary-care physician, and I do not furnish the correct referral at the time of service, I will be responsible for payment if my insurance company refuses my claim. I also understand that I am financially responsible for all service and material co-pays, deductibles and for any non-covered services at the time of service.

Returned Checks: There is a $35 fee for any check returned by the bank. This fee will be added to the unpaid balance and must be paid by cash or credit card.

Order and Payment Policy: I understand that materials (lenses, contacts, frames, etc.) must be paid for in full before they will be ordered or made. **In addition, any changes that I make to an order may result in additional fees/copays that I will be responsible for paying**. I further acknowledge that items left here at the office for more than **90 days** will be returned to stock or donated to charity and all amounts paid will be forfeited. No refunds will be given.

Patient's Name (printed): _____ Date of Birth: _____

Signature of Patient: _____ Date: _____

*****IF THE PATIENT IS A MINOR (UNDER 14) or YOU ARE SIGNING FOR THE PATIENT, PLEASE READ AND SIGN BELOW:**

If you are signing as a personal representative/caregiver of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

Representative Signature: _____ Relationship: _____

Representative Name Printed: _____ Date: _____

NO SHOW/SAME DAY RESCHEDULE POLICY:

As a courtesy to our patients, we make every effort to remind everyone of upcoming appointments through automated text reminders and phone calls. However, ultimately, it is the patient's responsibility to remember appointments they have scheduled. We realize that there may be times when you need to reschedule. We only ask that at least 24 hour notice be given so that we may offer the appointment to another patient**. A fee of $50 PER PATIENT may be charged** when a patient fails to show or decides to reschedule the day of their appointment. We understand that emergencies and sickness happen, and in those instances, fees may be waived at the discretion of the office administration. Repeated missed appointments may result in dismissal from the practice.

I have read and understand the above policy. Signature: _____

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PATIENT CONSENT TO SHARE PERSONAL HEALTH INFORMATION:

I acknowledge I was given the opportunity to review this office's Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature: _____ Date: _____

_____ (**initial**) I authorize Murray Vision Source to notify me of appointments, eyewear/material pickups and any other such information **via home phone, cell phone, email or text** at the numbers/email address that I provide. I further agree that a message may be left at the home or cell phone numbers that I provide if I am not available. MVS will never use my information for marketing purposes outside of the office.

I hereby authorize Murray Vision Source to share my personal health information with the named persons below.

*****IF NONE, PLEASE WRITE "NONE" ON THE LINE BELOW.*****

Name of Authorized Person(s): **Relationship to Patient:**

_____

_____

_____

Patient (ages 14 and over) or Parent/Representative sign below:

_____ Date: _____

*****Parent/Representative – please make sure that your name is also printed on one of the lines above even if you are the one signing.**

*****Please note that you as a parent or caregiver are always welcome in the exam room with the patient here at Murray Vision. This will be the ONLY OPPORTUNITY you will have during the appointment to speak with the doctor or the techs as medical information WILL NOT BE DISCUSSED in the waiting room or other public areas of the office.**

Initials of Staff - Reviewed: _____ Date: _____