Murray Vision Source Southern Eye Care

5630 West Main Street, Suite 5 609 Ozark Road

Dothan, AL 36305 Abbeville, AL 36310

**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)/Southern Eye Care (SEC) for any furnished services. I authorize MVS/SEC to release any medical or other information about me to any private insurance company, Medicare and Medicaid or other company and its agents, with might provide coverage to me.

**All Services are the Responsibility of the Patient**: MVS/SEC 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.

**Special Order Policy**: I understand that materials (lenses, contacts, frames, etc.) must be paid in full to be picked up from the office. 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 materials left here at the office for more than 90 days will be returned to stock and all amounts paid will be forfeited. No refunds will be given.

Patient’s Name (printed):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party (printed):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Responsible party signs if patient is a minor or is unable)

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**HIPAA Acknowledgement Receipt**

I acknowledge I was offered a copy of Murray Vision Source/Southern Eye Care’s notice of Privacy Practices. Please **INITIAL** next to your choice:

\_\_\_\_\_\_\_Yes, I would like to receive a copy of the office’s Notice of Privacy Practices.

\_\_\_\_\_\_\_No, I do not wish to receive a copy of the office’s Notice of Privacy Practices.

\_\_\_\_\_\_ (**initial**) I authorize Murray Vision Source/Southern Eye Care 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/SEC will never use my information for marketing purposes outside of their offices.

Due to HIPAA regulations, please list any authorized person(s) with whom we may discuss your appointments, diagnosis, insurance and/or payments or who may be allowed to pick up glasses or contacts for you from our office.

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

Patient or Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initials of Staff Reviewed: \_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_