MURRAY VISION CENTER, PC

Mathew G. Findlay, O.D.

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126 East 4800 South • Murray, Utah 84107
Tel (801) 262-2411 • Fax (801) 262-2412

PATIENT INFORMATION

NAME IN FULL _____
LAST FIRST MI

ADDRESS _____
STREET CITY STATE ZIP

(_____)_____ _____-_____-_____ _____ M / F _____-_____-_____
HOME PHONE BIRTHDATE AGE GENDER SOCIAL SECURITY #

_____ (_____)_____ (_____)_____ TEXT? ☐ Y ☐ N
EMPLOYER WORK PHONE CELL PHONE

SPOUSE_____ EMPLOYER_____

NAME OF RESPONSIBLE PERSON _____ PAT. EMAIL _____

NAME OF NEAREST RELATIVE/FRIEND _____ (_____) _____
PHONE

WHO REFERRED YOU TO OUR PRACTICE? _____

INSURANCE INFORMATION

PRIMARY INSURANCE CO._____

_____ _____-_____-_____ (_____)_____
NAME OF PERSON INSURED BIRTHDATE HOME PHONE

_____ (_____) _____
EMPLOYER WORK PHONE

GROUP #_____ID#_____ _____
SOCIAL SECURITY #

MEDICARE #_____ *SEE BACK FOR ADL. MEDICARE INFO.*

SUPPLEMENT OR SECONDARY INSURANCE CO. _____

_____ _____-_____-_____ (_____)_____
NAME OF INSURED BIRTHDATE HOME PHONE

_____ (_____) _____
EMPLOYER WORK PHONE

_____ _____
GROUP # SOCIAL SECURITY #

PAYMENT INFORMATION

PAYMENT FOR PROFESSIONAL SERVICES IS DUE UPON COMPLETION OF VISIT. BEFORE ORDERING GLASSES OR CONTACT LENSES, A DEPOSIT OF 1/2 DOWN IS REQUIRED WITH THE REMAINING BALANCE BEING PAID UPON DISPENSING. WE WILL BILL YOUR INSURANCE AS A COURTESY, BUT YOU ARE SOLELY RESPONSIBLE FOR THE WHOLE ACCOUNT.

PLEASE CHECK PAYMENT PREFERENCE: _____ CASH _____CHECK _____VISA/MC _____INS.

TERMS & CONDITIONS: IT IS AGREED THAT THE RIGHT & OWNERSHIP OF ANY PURCHASED MATERIALS SHALL REMAIN IN AND NOT PASS FROM MURRAY VISION CENTER, P.C. UNTIL THIS NOTE AND COST IS FULLY PAID. IN THE EVENT THIS CLAIM IS NOT PAID AND IF THIS ACCOUNT IS TURNED OVER TO AN AGENCY FOR COLLECTION, I AGREE TO PAY, IN ADDITION TO THE ACCOUNT BALANCE: ATTORNEY FEES; COURT COSTS; AND COLLECTION AGENCY FEES, COMMISSIONS AND CHARGES UP TO 40% OF THE ACCOUNT BALANCE.

A FINANCE CHARGE OF 2 PERCENT PER MONTH (ANNUAL RATE OF 24 PERCENT) OR A MINIMUM CHARGE OF $20.00, WILL BE CHARGED ON ALL BALANCES OVER 30 DAYS, REGARDLESS OF PENDING INSURANCE CLAIMS.

A $20.00 LATE CHARGE WILL BE ADDED IF A PAYMENT IS NOT RECEIVED BY DUE DATE. A $25.00 CHARGE WILL BE ADDED FOR RETURNED CHECKS.

X _____ _____
SIGNATURE DATE

– OVER PLEASE –

* MEDICARE INFORMATION* MEDICARE PATIENTS ONLY

"Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862 (a) (1) of the Social Security Act. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare Program standards, Medicare will deny or reduce payment for that service. I believe, in your case, Medicare is likely to deny or reduce payment for, the following reason(s):"

1) Medicare does not usually pay for refraction.
2) Medicare does not usually pay for supplies or medications.
3) Medicare does not usually pay for this many visits or treatments.
4) Medicare does not usually pay for this service.
5) Medicare does not pay for like services by more than one doctor during the same time period.
6) Medicare does not usually pay for this many services within this period of time.
7) Medicare does not usually pay for such an extensive procedure.
8) Medicare does not usually pay for after hour's charges.

"I have been notified by my physician that he believes, in my case, Medicare is likely to deny or reduce payment for the services identified above or the reasons stated. If Medicare denies or reduces payment, I agree to be personally and fully responsible for payment."

X _____ _____

Signature Date

Read and understand Notice of Privacy Practices.

_____ Date:_____