Financial Policy

Thank you for choosing **Morgan EyeCare** & **Perry EyeCare** as your eye care provider. Please understand that payment is due at the time services are provided. We accept Cash, Credit Cards, and Debit Cards.

Using insurance benefits?

- **When we are a Participating Provider** - All applicable Co-payments, Deductibles, Contact Lens Evaluations, and Refraction charges, when not covered by your Insurance Company, **are due at the time the service is provided**. ***Refraction tests*** are $35 and are necessary to determine if your eye prescription has changed, or if glasses will be necessary to correct your vision. **Medicare** and many supplemental insurances do NOT cover this test. All non-covered services, such as refraction testing, will be the responsibility of the patient and are due at the time of service.
- **When we are NOT a Participating Provider** – The patient is fully responsible for all charges. We will bill your insurance company; however, the remaining balance of the bill is your responsibility, whether or not your insurance company pays. Your insurance policy is a contract between the insurance company and yourself. Please note that some, perhaps all, of the services provided may NOT be covered under the Medicare program.

By signing below, I agree to pay all amounts owed within 30 days of when such amounts are incurred. I understand that it is my responsibility to provide my correct and updated insurance information and that the Practice will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amount(s) owing as set forth herein. I agree that interest will accrue on all past-due amounts at the rate of 18%per annum (1.5% per month) until paid in full. In the event any amount is referred to a third party debt collection agency, I agree that additional fee(s), as allowed by law, i.e., interest, court costs, reasonable attorneys's fees, etc., along with a collection fee of up to 40% of the principal amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11, will be my sole responsibility. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amounts(s) are incurred today or hereafter. I understand that it is my responsibility to provide my correct/updated insurance information and that the Practice will bill my insurance as a courtesy to me.

Signature _____ Date _____

Signature of Patient or Responsible Party

Printed Name _____

HIPPA Disclosure

We are required to notify you of our privacy practices and have you sign that you have reviewed this information. Morgan EyeCare & Perry EyeCare maintain a record of each patient visit, describing your history, symptoms, exam findings, diagnosis, and suggested treatment. Medical records are needed to provide you with proper care, coordinate with other physicians involved with your care, and for communication with your insurance company. We do not share your personal medical information with any unauthorized entity without your permission. More details of our Notice of Privacy Practices may be found in our written publication and on our website.

I have been given or offered a copy of the Practice's Notice of Privacy Practices, which describes how my health information is used and shared. I understand that the Practice has the right to change this notice at any time.

My signature below acknowledges that I have read and understand the Notice of Privacy Practices.

Signature _____ Date _____

Signature of Patient or Responsible Party

Printed Name _____