615.907.0433. • Murfreesboroeyecenter.com 1720 Old Fort Pkwy C160 • Murfreesboro, TN 37129

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES (HIPAA)

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail.

I acknowledge that I have been given the opportunity to read and receive a copy of Murfreesboro Eye Center PLLC's Notice of Privacy Practices.

Patient Printed Name _____

Patient Signature **OR** guardian if under 18:

_____ Date _____

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance benefits and I authorize payments of these benefits directly to **Murfreesboro Eye Center PLLC,** on my behalf for any services rendered. I authorize any holder of medical information about me to release to any applicable insurance carrier or their agents, any information needed to determine benefits payable for related services rendered. If I have other health insurance coverage, my signature authorizes my doctor to act as my agent, as above.

I understand that I am financially responsible to Murfreesboro Eye Center PLLC for any and all insurance deductibles, co-payments, or any services determined as a non-covered benefit by my insurance carrier.

Patient Signature **OR** guardian if under 18:

_____ Date _____

FINANCIAL POLICY

Our practice is committed to providing the best care for our patients and we are pleased to discuss our professional fees with you at any time. We file insurance as a courtesy to our patients, however, we do require you to pay your expected portion of the bill when services are rendered. This does include non-covered services, co-pays, deductibles, and fitting fees for contact lenses. Benefits are based on information received from your insurance provider on the day of service and does not reflect claims recently submitted. Final determination of your claim is based on when your claim is received and can change due to contract changes and policy cancellations. If your insurance has not responded within 60 days after filing, the entire balance will be your responsibility. We consider you the responsible party. Any balances owing 90 days from the initial date of service will be turned over to collections with an added 30% collection fee added to the remaining balance.

I have read and understood the Financial Policy and agree to the terms written there in.

Patient Signature **OR** guardian if under 18:

_____ Date _____