Murray Scholls Vision Center's
Financial Policy

In an effort to keep medical costs down, while maintaining a high level of professional care, Murray Scholls Vision Center has established the following policy of payment: **We accept cash and checks, as well as Visa, MasterCard, Discover, American Express and debit cards for your convenience. A $35 charge will be imposed for all returned checks.**

We file on **primary insurance** coverage only. We do not bill secondary insurance. We will gladly provide you the forms so that you may file with any secondary coverage you may have. Please note we are providing a service when we file your claim. However, the final responsibility for payment rests with you. If a clean claim is not paid after 90 days, we will transfer the balance to you and you will be responsible for paying any outstanding balances. Please note any benefits quoted are only an estimate. Difference between insurance estimate and what insurance actually pays is your responsibility. Once insurance is billed any balance owing is ultimately your responsibility.

Any overages not covered by your insurance are your responsibility and are due at the time of the order. Payment in full is required at the time of service unless any previous arrangements have been made. Custom made eyewear products are non-refundable. If you cancel your eyewear purchase prior to the job being completed at the lab and prior to billing insurance, you will be subject to a $50.00 restocking fee. Please be aware that there will be a separate charge if you are a contact lens wearer that ranges anywhere from $82 to $325 that insurance may not contribute toward. More details will be given before the contact lens evaluation is started.

Please be advised that if you request a copy of your entire medical record file from TVC, you will be charged a Detailed Records Transfer Fee of $45. If you request a copy of your Optomap photo in addition to your medical record file, you will be charged an additional $5.00.

Please notify us at least 24 hours in advance if you must change or cancel an appointment. When repeated failure to extend this courtesy occurs, an Exam Fee of up to $380 will be applied to your account. Please be considerate to our other patients and let us know if you are unable to keep an appointment.

I have read and understand and accept the above financial statement. I agree that I am responsible for all charges incurred on my account.

Insurance Assignment and Release:

I authorize my insurance benefits to be paid directly to Tigard Vision Center. I understand I am financially responsible for non-covered materials and services. Additionally, I authorize the Doctor and the staff and Tigard Vision Center to release any and all information required to process the claim.

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Signature **Date**

Notice of Privacy Practices:

In the course of providing services to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this information in order to treat you, obtain payment from insurance companies, or to refer you to another physician. The full copy of the Notice of Privacy Practices describes the uses and disclosures in detail. I acknowledge that I have received a copy of the Notice of Privacy Practices form Tigard Vision Center.

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Signature **Date**

Revised 04/30/2019