



8312 Lake Murray Blvd. Suite C
San Diego, CA 92119

Financial Responsibility/Signature On File

- I understand that payment is due at the time services are rendered.
- I understand that 24 hours notice is required if I am unable to keep my appointment. Otherwise, a \$35 NO SHOW FEE will be charged.
- I understand that there is a \$35 charge for all checks returned for insufficient funds.
- I understand that all discounts given will be voided after 60 days if payment is not received. If collection services are required, all discounts are voided.
- I understand all refunds will be made by check.
- I understand that if my prescription is filled outside of Lake Murray Optometric Center, and I am having trouble seeing or adapting to the prescription, Doctor and staff will be happy to recheck the glasses and/or the RX. However, there will be an office visit fee of \$49.
- I authorize Lake Murray Optometric Center to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.
- I authorize release of any information related to any claims to all my Insurance Companies or other relevant parties.
- I authorize payment of health benefits otherwise payable to me, directly to Lake Murray Optometric Center incurred by me. I further agree that in the event of nonpayment, I will bear the cost of collection and or court costs and reasonable legal fees should such action be required.
- I acknowledge that I am aware of The Privacy Act as stated by HIPAA at the office of
Lake Murray Optometric Center
- I permit a copy of this authorization to be used in place of the original.

Print name of Patient

Signature (Patient, Parent, or Guardian)

Relationship

Date