



www.Eyefinity.com/MURRAYVISIONCENTER  
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126 East 4800 South • Murray, Utah 84107  
 Tel (801) 262-2411 • Fax (801) 262-2412

**Mathew G. Findlay, O.D.**

**PATIENT INFORMATION**

NAME IN FULL \_\_\_\_\_  
 LAST FIRST MI

ADDRESS \_\_\_\_\_  
 STREET CITY STATE ZIP

(\_\_\_\_\_) \_\_\_\_\_ M / F \_\_\_\_\_  
 HOME PHONE BIRTHDATE AGE GENDER SOCIAL SECURITY #

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

SPOUSE \_\_\_\_\_ EMPLOYER \_\_\_\_\_

NAME OF RESPONSIBLE PERSON \_\_\_\_\_

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 # \_\_\_\_\_ 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 50% OF THE ACCOUNT BALANCE.

A FINANCE CHARGE OF 1.5 PERCENT PER MONTH (ANNUAL RATE OF 18 PERCENT) OR A MINIMUM CHARGE OF \$5.00, WILL BE CHARGED ON ALL BALANCES OVER 30 DAYS, REGARDLESS OF PENDING INSURANCE CLAIMS.

A \$5.00 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