Novi Ophthalmology, PC

PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing Novi Ophthalmology, PC as your health care provider. We are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment.

The following is a statement of our Patient Financial Responsibility Policy, which we require you to read and sign prior to seeing the Physician. Please let us know if you have any questions or concerns.
For your convenience we accept cash, check, Visa, MasterCard, American Express and Discover.

I understand I am financially responsible for treatment provided to me or my legal dependent by Novi Ophthalmology, PC.

I understand my insurance policy is a contract solely between me and my insurance company.

I understand that, as a courtesy, my physician will submit a claim to my insurance plan.

I authorize my insurance plan to make payments for covered services directly to my physician.

I understand I am responsible to pay at the time of service for copays, deductibles or non-covered services. I understand a $10.00 fee will be added if I do not pay my copay at the time of services.

If my physician does not participate with my insurance company, or if my insurance company has not paid the claim within 45 days, I understand the balance becomes my responsibility and I must pursue reimbursement directly from my insurance company. If there is a balance on my account, a statement of my charges and payment will be sent to my mailing address.

I authorize Novi Ophthalmology, PC to communicate with my health insurance company, in accordance with their Privacy Policy, regarding my policy coverage. I further authorize Novi Ophthalmology, PC to release information required by my insurance company to make payment for services rendered.

I understand a payment plan may be set up if I have financial difficulties. Charges over 90 days past due without a payment plan, may be sent to a collection agency and may result in being discharged from the practice.

I understand there is a $10.00 late fee for amounts over 30 days. I understand there is a $30.00 fee for returned personal checks.

I understand appointment cancellations with less than 24 hour notice or “No Show” patients are charged a service fee of $25.00. I understand I am responsible for this fee. I understand it cannot be billed to my insurance plan.

I have read the Patient Financial Policy and understand my responsibilities.