NewView EYE CENTER & ANTI-AGING
See what you've been missing

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Patient Financial Responsibilities

At NewView Eye Center you can expect to receive medical services in a caring and professional manner. We request that you keep scheduled appointments and arrive at the appointed time. If you are unable to keep your appointment, please give at least 48 hours notice. Cancellations of less than 24 hours prior to you're appointment or a no show for your appointment may require a $25 fee to reschedule.

Payment is due in full at the time of service. We accept personal check, cash or credit card. There is a $25 returned check charge. Please have your photo identification and current insurance information available for your visit to ensure your claim can be processed. Any difference between charges for services and insurance payment will be due and payable by you the patient (except where providers participate with your plan.) Billing statements for balances upon receipt in full. If your account is overdue, you will be responsible for any collection fess and costs.

Plan benefits are complex and unique for each subscriber. It is your obligation to be informed about your health insurance coverage – your unique benefits, coverage, deductibles, limitations, and responsibilities. You, and only you, are responsible to understand your coverage. You are responsible for confirming with your insurance carrier that the doctor you are seeing is a provider.

Be sure to bring and present referrals as required by your insurance company for your appointment. If you do not have your referral you may have to reschedule your appointment or you will be responsible for the entire cost of the examination.

At the time of your appointment, please remember to request your prescription refill(s) and submit any forms that need to be completed. Otherwise, there may be a $25 fee. This fee is for the time required to obtain your medical record, verification of information, and processing your request.

All of the physicians and the staff at NewView Eye Center appreciate your confidence in allowing us to participate in your eye care. Your signature indicates that you have read, understand and agree to all the policies and procedures of our Practice.

Patient's Name ________________________________

Signature of Patient / Responsible Party _________________________

Relationship to Patient __________________________

Date of Review and Signature ____________________