4033 Eastern Sky Dr.
Traverse City, MI 49684
231.932.9000
231.932.9156 f

NORTHERN VISION EYE CARE

Thank you for choosing Northern Vision Eye Care (NVEC) for your eye care needs. NVEC provides optical, medical and surgical eye care rendered by Robert K. Butryn MD and Amy S. Ranger MD. NVEC is a participating member of the Northern Michigan Health Network and is designated as a Patient Center Medical Home Neighbor practitioner, Specialist.

FINANCIAL POLICY

- Co-pays are required at the time of service
- You are responsible to know your insurance coverage/benefits/eligibility
- Bring your current insurance cards with you to each visit, without that information we will not be able to bill properly
- If your insurance changes retroactively to a company we do not participate with, you are responsible for payment in full at time of service
- If current health insurance information cannot be provided at each visit, you will be responsible for payment in full
- **You will be asked to verify your address, phone, and insurance information at each visit and once a year you will be required to complete a Patient Registration form**
- Workers Compensation or automobile accident claims will be billed directly to the carrier in accordance with Michigan law
- Please check to make sure you have your referral before your appointment
- If you need to cancel an appointment, please notify NVEC 24 hours in advance
- After two consecutive no show appointments, a $25 fee will be assessed to your account, non-sufficient fund checks are subject to a $25 administrative fee for each occurrence
- If you have included a cell phone you are giving our office or agent permission to call that phone

Please initial and date that you have read and agree to the above Financial Policies

_____

PLEASE CONTACT ME BY (FILL-IN ALL THAT APPLY):

Home #: _____

OK to leave a message? Y N

Work #: _____

OK to leave a message? Y N

Fax #: _____

Email address for written communication:

_____

AUTHORIZATION TO PAY/AUTHORIZATION TO RELEASE MEDICAL INFORMATION

By signing below you are authorizing both treatments and the release of medical health information necessary to process your insurance claims. You are also authorizing the release of your medical information to referring doctors and insurance companies on behalf of Northern Vision Eye Care. If applicable, this authorizes us to bill Medicare and release any information needed to determine payment for any specific date of service.

Patient Name(print): _____

Signature: _____ Date: _____

Parent/Guardian if patient is a minor: _____ Date: _____

Northern Vision Eye Care delivers state-of-the-art medical, surgical and optical eye care with a passion for excellence, individuality and community service