EYE CARE OF MAINE

325A Kennedy Memorial Drive
Waterville, Maine 04901
207-873-2731
Fax: 207-873-1106

123 Somerset Plaza
Pittsfield, Maine 04967
207-873-2731
Fax: 207-873-1106

349 Wilton Road
Farmington, Maine 04938
207-873-2731
Fax: 207-873-1106

35 Greenville Road
Monson, Maine 04464
207-873-2731
Fax: 207-873-1106

ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT AND/OR

ASSIGNMENT OF BENEFITS

I understand I need to provide the office with all insurance card (s) at the time of the appointment.

I understand and agree that I am financially responsible for all charges for all services rendered. This includes all medical services, or visit, routine examination, refraction, testing, contact lens services and any other screening ordered by the doctor or staff of Eye Care of Maine.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance. I understand that health information about me may be shared with my health insurance carrier (s) or other third-party payers responsible for paying for my health care. I understand that I may choose to pay privately in full if I do not wish certain sensitive health information to be disclosed to my third-party payer.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out of network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the service(s) I receive and I agree to make payment in full any balance not covered by my insurance.

I understand it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain that referral. I understand that without this referral, my insurance will not pay for any services and that I will be held financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree I am responsible for the balance in full.

I understand that I have a right to receive a copy of this authorization.

Printed Patient Name (or legal representative if applicable):

Patient Signature: Date: