



Consent for Care and Treatment Financial Agreement

Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. Some or all services and material provided to you may not be covered as “reasonable and necessary” under Mainecare, Medicare, and/or other medical insurances. The balance is your responsibility whether your insurance company pays or not. Billed charges are due upon receipt. Vision Care of Maine needs to be notified of any updates or changes to your insurance, prior to any appointments or procedures. We cannot bill your insurance company unless you give us your insurance information. If your coverage changes and our office is not notified prior to receiving services, you are responsible for the charges. Discounts applied to services and material cannot be combined with billing an insurance plan.

Referrals and Prior Authorizations

HMO or PPO patients requiring a referral: You are responsible for making sure your visits with our office are authorized by your primary care physician (PCP). Our billing staff can assist you in obtaining prior authorizations needed. This authorization must be obtained before your scheduled visit. If you do not have the proper authorization, your appointment could be rescheduled.

Deductible and Co-Insurance:

We are unable to verify if your deductible and/or out of pocket expenses have been met. You will be responsible for any balance due that was not covered due to being applied to deductible/out of pocket expenses.

Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

By signing below, I acknowledge that I have read and/or received a copy of Vision Care of Maine’s financial policy.

Signature: _____ Date: _____

Protected Health Consent

HIPAA Policy

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); Obtaining payment from third party payers (e.g., my insurance company); The day-to-day healthcare operations of your practice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I acknowledge that I have read and/or received a copy of Vision Care of Maine's Notice of Privacy Practices, Professional Service Policies and Signature Authorization.

Signature: _____ Date: _____