PAYMENT AUTHORIZATION AND INFORMATION RELEASE FORM

PAYMENT AUTHORIZATION FOR OFFICE & AMBULATORY SURGERY CENTER VISITS

Name: DOB: Chart #:

I request that payment of authorized health insurance benefits be made to me or on my behalf to Vision Care of Maine (VCOM), for any services furnished to me by providers within their group or in/by VCOM's ambulatory surgery center. I authorize VCOM, who holds medical information about me, to release to my health insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I understand, and by signing this document agree, that I am responsible for payment of all charges not paid by other payers (including deductibles, co-payments, non-covered services and services not authorized by my primary care doctor when required (co-payments not paid on date of service result in an additional $10.00 Administrative Fee)).

I further understand and agree that in the event that VCOM incurs collection expenses, attorney's fees, or other costs in connection with any actions taken to collect payment for any charges for which I am liable, (as set forth above), I will promptly pay VCOM for such items. Furthermore, I understand that there shall be assessed against any outstanding balance, an interest charge of 1 1/2 percent per month, and that I am responsible for such interest charges.

DISCLOSURE OF MEDICAL INFORMATION

I authorize those of my family members whom I have designated to be in attendance with me at the time of my examination and to be in attendance to hear VCOM discuss the diagnoses and treatment plans as they relate to my eyes. I authorize the physician and staff letter. I authorize the physicians and staff of VCOM, to renew my eye prescriptions by letter or phone or FAX to the pharmacy, optician and/or my designee or me. I authorize the physicians and staff of VCOM, to remind me of my appointments by sending a postcard through the mail, by e-mail, by phone call, or by leaving a message on my answering machine and/or voice mail. I also give my family members permission to-receive this information on my behalf.

I understand and consent to the disclosure by physicians, or staff, of VCOM, and any business associates of VCOM, for the purpose of conduct of any actions needed to collect any payments that I may owe, including interest, fees, costs, attorney's fees or other expenses related to action taken to obtain payment of charges otherwise unpaid, as set forth above.

This authorization is sufficient for tile initial record disclosure and for any subsequent disclosures to the same party for a period not to exceed 30 months unless otherwise specified by me. I understand that I may refuse authorization to disclose all or some of my health care information but this refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences. I also understand that this authorization may be revoked by me at any time by executing a written, oral, or electronic revocation with my signature and date. I understand that this revocation may be the basis for denial of health benefits or other insurance coverage or benefits. I understand that I am entitled to a copy of this authorization form.

Signature: Date:

1 Ridgewood Drive, Bangor, ME 04401 Phone: 207.945.6200 Fax: 207.990.3015
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