Insurance Release Authorization

I request that the payment of authorized benefits be made either to me or on my behalf to Midcoast Eyecare LLC., for any services furnished to me or my minor/child, or the patient for whom I have legal responsibility. I authorize any holder of medical information to release to the Health Care Financial Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and I am responsible for only the deductible coinsurance and non-covered services.

____ ____________________
Please print name of Patient Date

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Signature of Patient, Guardian or Personal Representative

Financial Agreement

I acknowledge that payment is due at the time of treatment unless other arrangements are made. I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of the patient whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me of my responsibility for the payment of all charges.

____ ____________________
Please print name of Patient Date

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Signature of Patient, Guardian or Personal Representative