At our practice, we provide comprehensive eyecare to ensure you are seeing your best. We accept most vision care plans and major medical insurances. Below is a guide to help determine what type of coverage will be used.

{Vision}

A **vision exam** includes screening for eye diseases and measurements for glasses and contact lenses.

Reasons for vision exams:

- To obtain glasses and contact lens prescriptions.

Diagnosis reasons for a vision exam:

- Routine eye wellness
- Myopia (nearsightedness)
- Hyperopia (farsightedness)
- Presbyopia
- Astigmatism

A vision exam is covered by vision insurance plans. If abnormal findings are discovered during your routine eye exam, you will be asked to return for a medical eye exam with additional testing. If a condition is diagnosed that requires a referral to a specialist, then your exam will be billed to your medical insurance.

{Medical}

A **medical eye examination** is performed to evaluate abnormal findings and monitor existing medical conditions.

Reasons for a medical exam:

- To manage any disease or abnormality that could result in a decline of vision that is not prescription-related.

Diagnosis reasons for a medical exam (not limited to):

- Diabetes/Prediabetes
- Visually significant cataract
- Glaucoma/Glaucoma suspect
- Age-related macular degeneration
- Retinal hole/tear/detachment
- Anatomical narrow angle
- Conjunctivitis
- Hydroxychloroquine/Plaquenil use

I have read and acknowledge the policy regarding insurance billing.

Patient/Representative Printed Name: _____ Signature: _____
Date: _____

July 15, 2026

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

_____

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

_____

Signature of Patient, Guardian or Personal Representative

No-Show & Late Cancellation Policy

We value your time and strive to provide timely care for all our patients. Missed appointments or late cancellations prevent other patients from receiving needed care.

Policy Details:

- A **"no-show"** is when a patient does not arrive for a scheduled appointment and has not called to cancel or reschedule at least 24 hours in advance.
- Cancellations made **less than 24 hours before** the appointment may also be considered a no-show.
- A **$50 fee** will be charged for each no-show or late cancellation. This fee is **not covered by insurance** and must be paid before your next appointment.
- Fee will be instituted if/when a patient no shows/late cancels for a **third time.**

Multiple no-shows may result in limited scheduling options or dismissal from the practice.

How to Avoid a No-Show Fee:

- Call us at **207-594-9555,** *at least 24 hours* before your appointment to cancel or reschedule.
- If you are running late, please call so we can try to accommodate you.

Acknowledgment:

I have read and understand the No-Show & Late Cancellation Policy. I agree to the terms and understand that I am responsible for any applicable fees.

Patient Name: _____

Signature: _____Date: _____

May 29, 2026

Notice of Private Practices
Patient Acknowledgment

Patient Name: _____ Date of Birth: _____

I have received this practices' Notice of Privacy Practices written in plain language. This notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practices' legal duties with respect to my protected health information. The notice includes:

*A statement that this practice is required by law to maintain the privacy of protected health information.
*A statement that this practice is required to abide by the terms of the notice currently in effect
*Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
*A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
*A description of uses and disclosures that are prohibited or materially limited by law.
*A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
*My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
*SMS consent is not shared with third parties.

*The right to complain about this practice and to the Secretary of HHS if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a complaint.
*The right to request restrictions on certain uses and disclosures of my protected health information. and that this practice is not required to agree to requested restriction.
*The right to receive confidential communications of protected health information.
*The right to inspect and copy protected health information.

*The right to amend protected health information.
*The right to receive and account disclosures or protected health information.
*The right to obtain a paper copy of the Notice of Privacy Practices upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practices current Notice of Privacy Practices on request.

Signature_____Date_____

Relationship to Patient (if signed by a personal representative of patient) _____

Date:	Time:

Patient Demographics **Please complete all information:**

Patient Last Name:	First Name:	Middle:	Preferred:
Sex: ( )M ( )F / Gender Identity:	DOB:	Social Security #:	
Address:	City:	State/Zip:	
Preferred Phone #: ( ) Cell ( ) Home	Alternative Phone #: ( ) Cell ( ) Home		
Email address:	Preferred Reminder Method: ( ) Text ( ) Call ( ) Email		

Guarantor/Legal Guardian of Minor:

Last Name:	First Name:	Middle:	Preferred:
Sex: ( )M ( )F / Gender Identity:	DOB:	Social Security #:	
Address:	City:	State/Zip:	
Preferred Phone #: ( ) Cell ( ) Home	Alternative Phone #: ( ) Cell ( ) Home		
Email address:	Relationship to patient:		

Emergency Contact: Is this the same as guarantor/guardian? ( ) Y ( ) N

if yes, no need to complete the following section

Last Name:	First Name:	DOB:
Address:	City:	State/Zip:
Preferred Phone #: ( ) Cell ( ) Home	Alternative Phone #: ( ) Cell ( ) Home	
Email address:	Relationship to patient:	

Primary Care Physician:	Preferred Pharmacy:
Interpreter needed? ( ) Y ( ) N	Spoken Language: Written Language:

Text Messaging and Email Consent Form

If you wish to receive text message or email appointment confirmations and have not already completed this form, please fill in your details below and return to a practice representative. Thank you.

Midcoast Eyecare, LLC (Damariscotta Eyecare) has partnered with a service which enables us to contact you by text message or email to confirm appointments. The office may also contact you via text message and/or email to contact you regarding other services, for example, outgoing referrals, or change in appointment status.

The appointment reminder services will send you a reminder via text message one day and five days, before your appointment is scheduled.

If your mobile number or email address change, please remember to keep us up to date with your latest information.

Damariscotta Eyecare cannot be held responsible for messages sent to a mobile number or email address you have supplied but you no longer own, or if someone has access to your phone or email and can view your messages. SMS consent is not shared with third parties.

SMS Terms of Service

By opting into SMS from a web form or other medium, you are agreeing to receive SMS messages from Damariscotta Eyecare. This includes SMS messages for customer care. Message frequency varies. Message and data rates may apply. See privacy policy at [https://midcoasteyecare.com/wp-content/uploads/2025/06/HIPAA-Form.pdf]. Message HELP for help. Reply STOP to any message to opt out.

Signed: _____ Date: _____

Printed Name: _____DOB: _____

Mobile telephone number: _____

Email address: _____