EYE CENTER NORTHEAST, 955 Broadway, Bangor, ME 04401

1.Medicare Assignment of Benefits: I request that payment of authorized Medicare benefits be made on my behalf to Eye Center Northeast for services furnished to me by ECNE. I authorize ECNE to release to CMS any and all information needed to determine benefits. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. ECNE accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare Carrier.
2.Financial Agreement: I understand and agree that I am individually obligated to pay the full charge for all services rendered to me by ECNE. If co payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to ECNE. I understand that there is no guarantee of payment from any insurance company or other payer. I request that payment of authorized benefits be made on my/or my dependents behalf to ECNE for any services rendered by my eye care provider. I agree to pay all charges for the services by ECNE which are not paid by my health insurance or other payer. All charges are due and payable at the time of service or when I receive the bill. I accept responsibility to obtain all referrals or pre-authorizations and to comply with all requirements of any insurance plan.
3. Non-Covered Services: I understand that ECNE contracts with health care service plans. I accept full financial responsibility for all items or services which are determined by the health care service plans to be not covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a hcsp or in the benefit summary of the health care service plan furnished to the patient and treatment or tests not authorized by the hcsp. I agree to cooperate with ECNE to obtain necessary hcsp authorizations.
4.Release of Information: ECNE may disclose all or any part of my medical record and/or financial ledger, including information sent by phone, fax, mail or secure email including diagnosis and records of treatment rendered and including treatment of alcohol or drug abuse, psychiatric illness, communicable disease or HIV, to any person or corporation (1) which is or may be liable or under contract to ECNE for reimbursement for services rendered, and (2) any health care provider for continued patient care. I authorize ECNE to disclose my information which refers to treatment or diagnosis to my Pharmacy so we are able to E-Prescribe and Receive a current list of medications.
5. Consent for Health Care Services: I authorize consent for medical treatment by my eye care provider or healthcare staff for myself/or my dependent at ECNE to perform the necessary examination and treatment, including installation of eye drops, surgical procedures and application of contact lenses if prescribed by my provider. Dilation of my eyes is necessary to obtain the best view of your retina, but can cause blurred vision for several hours. We recommend you have a driver after dilation.
6. HIPAA Privacy Policy: I acknowledge that I have been offered a hard copy of ECNE's Privacy Policy or have been directed to obtain a copy on ECNE's website, www.eyecenternortheast.com

Assignment of Benefits, Financial Agreement, Release of Information and Consent to Treat

Signature of Patient or Authorized Individual: _____ Date: _____