EYE CARE & EYE WEAR CENTER of MAINE

Douglas Gauvreau, OD Eric Roush, OD Jennifer Haverkamp, OD

INSURANCE BILLING SIGNATURE FORM

PLEASE READ & SIGN

Your insurance company may not pay for all your COVERED services. A "covered service" may require that you pay your deductible and/or co-pay and co-insurance. In the event that your insurance company does not pay all or part of your claim, you agree to pay for services rendered.

If the doctor determines that your eye problem is due to a medical condition, including annual diabetic examinations, we will bill your medical insurance for your office visit.

Your signature below authorizes Eye Care & Eye Wear Center of Maine to bill your insurance company on your behalf. It also serves to authorize any information be provided that your insurance company may require to process your claim.

I am familiar with the Eye Care & Eye Wear Center of Maine Notice of Privacy Practices.

NAME of INSURANCE PLAN:_____

PATIENT NAME:_____ DATE of BIRTH:_____

POLICYHOLDER:_____ DATE of BIRTH:_____

POLICYHOLDER PLACE of EMPLOYMENT:_____

_____ _____

SIGNATURE DATE

RESPONSIBLE for PAYMENT (if patient is a minor):_____

SOCIAL SECURITY NUMBER:_____

_____ _____

SIGNATURE DATE