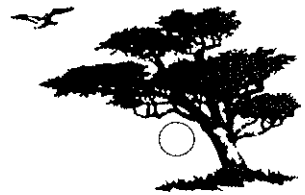


CHRISTEN ALLAMAN, M.D.
EYE CARE MEDICAL GROUP, INC.



LIFETIME AUTHORIZATION OF INSURANCE BENEFITS and BILLING INFORMATION FOR ALL PATIENTS

Welcome to Eye Care Medical Group, Inc. Because the insurance companies change their carriers, plans and benefits frequently, it is difficult for us to verify that your insurance carrier is one that we are contracted with at the time of your visit. We do attempt to confirm your insurance coverage, but is not always possible to ascertain this information accurately at the time of your office visit. You are encouraged to verify your benefits and whether Eye Care Medical Group, Inc. and our doctors are contracted **PRIOR** to your visit. Please be aware that we bill your insurance as a service to you. It is your responsibility to be up to date on your insurance policy and its requirements, covered physicians, covered services, deductibles, and copayment amounts. Regardless, you will be seen by our doctors as we do not want to withhold services inappropriately. When you check in at the front desk, we will ask to make a copy of your insurance card for our records. **Making a copy of your insurance card does not confirm that you have coverage with us.** If we do not contract with your insurance company, we will provide you with a statement that will outline all necessary information required for reimbursement.

By signing below, I request that payment of insurance benefits be made on my behalf to Eye Care Medical Group, Inc. for any services furnished to me by their physicians/suppliers. I understand that my signature request that payment be made and authorizes the release of any medical information necessary to ensure payment.

MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made to me or on my behalf to Eye Care Medical Group, Inc. for any services furnished me. I authorize holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services. I further understand that Eye Care Medical Group has agreed to accept the allowed charge determined by Medicare as full charge. Medicare pays 80% of that charge and I understand that I am responsible for the balance of the charge, co-insurance and non-covered services. Co-insurance and deductibles are determined by the carrier. I understand that Medicare excludes all refractive services from their coverage. I agree to be personally and fully responsible for the refractive portion of my exam. Medicare (and most other insurances) does not cover eyeglasses or medications in most cases. If other health insurance coverage is indicated (secondary insurance) my signature authorizes releasing of the information to that insurer or agency.

HMO/PRIOR AUTHORIZATION PATIENTS: I understand that I am ultimately responsible for authorizations for care/treatment to be provided by Eye Care Medical Group, Inc. If for ANY reason a service is not authorized or is denied, I assume full responsibility for any and all charges, including copayments and deductibles.

It is your responsibility to know whether Eye Care Medical Group, Inc. is a provider for your insurance company. If we provide services to you and we ARE NOT a contracted provider, your insurance company will notify us that you are liable for either all or a large part of your bill.

PRIVATE PAY PATIENTS: Payment for services rendered is required at the time of service. We offer a 10% discount for your cooperation and payment. If at anytime in the future you become insured with medical or vision coverage please let our staff know.

We are committed to providing quality service. With the changes in the health care arena, this can be a time consuming process. Thank you in advance for your cooperation and patience.

Eye Care Medical Group, Inc.

Christen Allaman, M.D. Geraldine Brooks, O.D. Cary Carlos, O.D.

I have read the above information. I understand that all charges for services rendered are ultimately my responsibility. Should Eye Care Medical Group, Inc. not be a contracted provider, or if the service rendered is not a covered benefit under my plan, I am responsible for all charges related to the services provided to me and will pay in full for all such charges.

PATIENT (RESPONSIBLE PARTY) SIGNATURE

DATE

A COPY OF THIS FORM WILL BE PROVIDED TO YOU AT YOUR REQUEST

2/2007

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