MARYLAND EYE
CONSULTANTS & SURGEONS

Financial Waiver Form

This waiver is to certify that I will receive medical care from Dr. John Ladas, Dr. Pamela Cheung, Dr. Jerome Gabry, Dr. Aisha Macedo, or Dr. Ankur Gupta. By signing, the patient certifies that, should their insurance deny payment, the patient will assume responsibility for 100% of today's charges and waive any contractual adjustments or obligations by the provider. I understand that I am responsible for obtaining any referrals if my insurance requires. I am aware that I am liable for the cost of all services rendered if I fail to obtain a correct referral.

_____ _____
Signature Date

Patient Name:_____ Date of Birth:_____

Relationship to Patient:_____
(If signed by personal representative of patient)

For Office Use Only
Patient declined to sign: _____ Date: _____ Staff member's signature