MARYLAND EYE
CONSULTANTS & SURGEONS

JOHN LADAS MD, PhD PAMELA CHEUNG MD MICHAEL BAUM MD
JEROME GABRY MD AISHA MACEDO MD SHAZIA AHMED MD

Financial Waiver Form

This waiver is to certify that I have received medical care from Dr. John Ladas, Dr. Pamela Cheung, Dr. Michael Baum, Dr. Jerome Gabry, Dr. Aisha Macedo or Dr. Shazia Ahmed. 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

2101 MEDICAL PARK DR, SUITE 101 SILVER SPRING, MD 20902
PHONE (301) 681-6600 FAX (301) 681-3799