SILVER SPRING OPHTHALMOLOGY, LLC

8630 FENTON STREET, SUITE 800
SILVER SPRING MD, 20910
PHONE 301-585-8880 FAX 301-585-6521

PATIENT AUTHORIZATION OF MEDICARE AND INSURANCE BENEFITS

Patient's Name:_____

I authorize payment to this center on my behalf for any services furnished to me. I authorize release of medical information about me to the Center, for Medicare and Medicaid Services (CMS) to determine benefits payable to related services. I certify that the information I have reported with regards to my insurance is correct.

I understand that I am responsible for co-insurance and services not allowed by my insurance company. In Medicare assigned cases, provider agrees to accept the charge determination of Medicare carriers and I am responsible for the Medicare deductible, co-insurance or the 20% Medicare does not pay, and for any non covered services. I further understand and agree that if my account should be placed in collection for any reason of non-payment, that I will also be responsible for any and all such collection fees.

I realize that I will receive a bill from my doctor's office, for the surgical fee, Silver Spring Ophthalmology, LLC for the facility fee, and if I require anesthesia, the anesthesia department.

My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

I request that the payment of authorized Medigap or other secondary insurance benefits be made either by me or on my behalf to Silver Spring Ophthalmology, LLC or any physician of the group, for services provided to me by a physician of the group. I authorize any holder of medical information about me to release it to my Medigap insurer, _____ needed to determine these benefits payable for related services.

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

On the day of my surgery I may request an estimated price for my surgery and anesthesia costs from Silver Spring Ophthalmology, LLC.

SIGNATURE: X_____ DATE_____