Greater Baltimore Vitreoretinal Specialists, LLC
Christina Antonopoulos, MD, FACS
(410) 696 - 4785
hello@gbretina.com

Signature on File, Assignment of Benefits, Financial Agreement

Printed Patient Name: _____

Date of Birth: _____

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Greater Baltimore Vitreoretinal Specialists, LLC for services rendered to me. I authorize any 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 benefits payable for services rendered. I understand my signature requests that payment be made and authorizes release of medical information necessary for processing and reimbursement of claims. If another health insurance provider is listed as a Secondary Insurance (Item #9 of the HCFA 1500 claim form), my signature likewise authorizes release of the information to the insurer shown. Greater Baltimore Vitreoretinal Specialists, LLC accepts the charge determination of Medicare, and I am financially responsible for coinsurance, deductibles and non-covered services.

OTHER INSURANCE: I request that payment of authorized benefits be made on my behalf to Greater Baltimore Vitreoretinal Specialists, LLC for services rendered to me. I authorize any holder of medical information about me to release to my insurance provider any information needed to determine benefits payable for services rendered. I understand my signature requests that payment be made and authorizes release of medical information necessary for the processing and reimbursement of claims.

FINANCIAL AGREEMENT: I agree that in return for the services provided by Greater Baltimore Vitreoretinal Specialists, LLC I will pay my account at the time service is rendered or will make arrangements to honor my financial obligations that are satisfactory to the practice. Most insurance companies require the beneficiary to pay co-payments and deductibles at the time of service without exception. I recognize that it is not in the power of Greater Baltimore Vitreoretinal Specialists, LLC to waive beneficiary co-payments and deductible balances. I understand that I am primarily responsible for the payment of any services not covered by my insurance.

_____ _____

Signature of patient or authorized representative Date