COMPREHENSIVE DERMATOLOGY CENTER

AUTHORIZATION FORM

Patient Name: _____ Date:_____/_____/_____

RELEASE OF INFORMATION: I understand the release of medical information to my primary car or referring physician, to consultation if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payments of medical benefits to the physicians.

PAYMENT POLICIES:

PATIENTS WITH INSURANCES WE PARTICIPATE WITH: If we participate (contract) with an insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible for paying your annual deductible, co-payment and charges for any non-covered, cosmetic services. In the event that we are not aware that a particular service is not covered by your plan, you will be billed for the balance after we obtain a denial from your insurance carrier.

PATIENTS WHO HAVE INSURANCE COVERAGE WITH A CARRIER THAT WE DO NOT PARTICIPTATE WITH: Patients covered by private, commercial plans in which our physician is not a member will be responsible for payment in full at the time of service, regardless of the benefits and payment policies of your carrier. We will not file claims directly with your insurance company. Patients may elect to independently seek reimbursement from their carrier, if so we can provide you with documentation of the services performed.

MEDICARE: We are participating with Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductable, paying for the co-payment and charges for non-covered/cosmetic services. If we participate with your secondary/supplemental carriers, we will file a claim for you. However, in the event that the secondary does not pay within 60 days, patients will be billed for the balance. This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to the payer if they require it for the proper consideration of a claim.

I authorize any holder of medical or other information about me to be released to the Social Security Administration, Center for Medicare and Medicaid Services or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

CANCELLATION POLICY: I understand that I may be liable for a charge of $30 if I fail to give 24 hours notice to cancel an appointment.

RETURN CHECK POLICY: Comprehensive Dermatology, PC charges $30 for all returned checks.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

_____ _____/_____/_____

Patient or Responsible Party Signature Date

* If you have a Supplemental Policy to which your Medicare carrier automatically "cross over": I request authorized benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above supplemental carrier any information needed to determine these benefits or the benefits payable for related service.

_____ _____/_____/_____

Signature as it appears on supplemental card Date