PAYMENT & INSURANCE AUTHORIZATION FORM

DATE: _____

NAME: _____
First Middle Last

PAYMENT & INSURANCE AUTHORIZATION FORM

I hereby authorize payment directly to South Miami Dermatology of all benefits applicable and otherwise payable to me from my insurance carrier, Medicare, HMO, or any other third party payor for service rendered to me. I understand that I am financially responsible to South Miami Dermatology for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits. Medicare assigned benefits will be accepted as applicable, however, co-insurance, deductibles, and non-covered services are the financial responsibility of the patient. If there is no insurance coverage, all office fees are payable at the time service is rendered. We accept ***cash, check, Visa, Mastercard, Discover, and American Express*** as forms of payment.

(Patient's/Guardian's Signature) _____
If Patient is a minor, please provide guardian's information
Name _____ SSN _____ Date of Birth _____

MEDICARE ONLY
Authorization to Assign Medicare Benefits to Physician

(Patient's Signature) _____

For Office Use Only
Witness Signature: _____