SKIN AND CANCER ASSOCIATES

Insurance Assignment Agreement/Privacy Notice Acknowledgment

****PLEASE SIGN THE RELEASE(S) BELOW THAT PERTAINS TO YOUR TYPE(S) OF INSURANCE****

COMMERCIAL INSURANCE

I, the undersigned, certify that I (or my dependent) have insurance coverage through _____

_____, and assign directly to Skin and Cancer Associates (SCA) all
Name of Insurance Company(ies)

insurance benefits, if any, otherwise payable to me, for services rendered. I hereby authorize SCA to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. **I understand that I am responsible for my health insurance deductibles and coinsurance.**

_____ _____ _____
Beneficiary/Patient Signature Relationship Date

MEDICARE and/or MEDICAID

Lifetime Authorization. Medicare and Medicaid patient certification. Patient certification authorization to release information and payment request.

I certify that the information given by me in applying for payment under Title XVIII and or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits me made on my behalf. I assign the benefits payable for physician(s) services. **I understand that I am responsible for my health insurance deductibles and coinsurance.**

_____ _____ _____
Patient Signature Print Patient Name Date

MEDIGAP

NOTE: IF YOU SIGN HERE YOU SHOULD ALSO SIGN FOR MEDICARE ABOVE.

Beneficiary Signature Authorization.

I request that payment of authorized Medigap benefits be made on my behalf to SCA for services furnished to me by the physician(s) of SCA. I authorize any holder of medical information about me to release to my Medigap carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Beneficiary/Patient Signature Print Beneficiary/Patient Name

_____ _____
HIC (Medicare) Number Medigap Number

_____ _____
Name of Medigap Insurance Company Date

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____ _____
Patient Signature Print Patient Name Date

_____
Parent or Authorized representative (if applicable)