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 Family Dermatology of North Florida
all
Name of Insurance Company(ies)

insurance benefits, if any, otherwise payable to me, for services rendered. I hereby authorize Family Dermatology of North Florida 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 Family Dermatology of North Florida for services furnished to me by the physician(s) of Family Dermatology of North Florida. 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)