Patient Name:_____
Please Print

Medicare Recipient:

Yes / No If you or your spouse work in a company that has more than 20 employees, do you receive health benefits through their group plan?

Yes / No Are you covered by a Medicare Advantage Plan which replaces your Medicare?

Yes / No Are you covered by a health plan which makes Medicare your secondary coverage?

Yes / No Do you receive medical assistance through any state-aid programs?

Medicare Authorization:
I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration or its intermediaries 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.

Signature:_____ Date:_____

Supplemental Authorization:
I authorize MEDIGAP claims be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the submitted MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services. I authorize and direct my insurance carrier(s) to issue payment check(s) directly to Treasure Coast Dermatology.

Signature:_____ Date:_____

Non-Medicare Recipient:

I authorize the release of medical information to my primary care physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize and direct my insurance carrier(s) to issue payment check(s) directly to Treasure Coast Dermatology.

Signature:_____ Date:_____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan with which we participate. For those patients, applicable co-payments and deductibles will be collected. In the event that your account must be turned over to collections, a $10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Signature_____ Date:_____