PLEASE SUBMIT YOUR INSURANCE CARDS SO THAT WE MAY MAKE COPIES FOR YOUR RECORDS

This office is required to keep your signature on file authorizing us to file claims to Medicare or other payors for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services or its contractors 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 to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

______________________________ ______________________________

Signature as it appears on Medicare Card Date

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare automatically "crosses over", we are required to keep a separate signature on file.

I request authorized MEDIGAP benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

______________________________ ______________________________

Signature as it appears on MEDIGAP Date

ALL OTHER INSURANCE

I/we authorize NELSON DERMATOLOGY to furnish complete information to my insurance carrier and/or its intermediaries regarding services rendered. I/we agree that medical photographs may be taken in the course of treatment. I/we agree that photocopies of this form will be as valid as originals. I/we jointly and severally accept full responsibility for all charges for your services rendered to the above patient and agree to pay all charges due upon receipt of statement. I/we agree to be responsible for any costs incurred in the collection of amounts in case of default including reasonable attorney's fees.

______________________________ ______________________________

Patient Date