Dermatology
Surgical & Medical Group

MEDICARE
REFERRAL INFORMATION

Patient Name:_____Nickname: _____ Today's Date ___/___/___

Other family members that are patients _____

Referred by:_____Primary Care Physician _____

In case of Emergency, who should be notified?_____ Phone ( )_____

RELEASE OF INFORMATION

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ Date ___/___/___

I authorize medical personnel to leave messages regarding my treatment plan and/or diagnosis on voicemail or answering machines, or with my spouse, caretaker or guardian, when I am not available by telephone.

Patient or Responsible Party Signature _____ Date ___/___/___

PATIENT FINANCIAL POLICY

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for their annual deductible and paying for their 20% copayment. We do bill secondary insurance as a courtesy for patients; however, in the event that the secondary does not pay within 60 days patients will be balance billed.

Note: If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

Patient or Responsible Party Signature _____ **Date** ___/___/___

SIGNATURE ON FILE

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer 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 Health Care Financing Administration or its intermediaries or carrier 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 as it appears on Medicare Card _____ **Date** ___/___/___

If you have a secondary insurance to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

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

Signature as it appears on secondary insurance card _____ **Date** ___/___/___