General Assignment of Benefits

I request that payment of authorized insurance benefits be made on my behalf to the organization listed below for any equipment or services provided to me by those organizations. I authorize the release of any medical or photocopies of information to my insurance company in order to determine the benefits payable for the services rendered by this provider.

I understand that I am financially responsible to the organization listed below for any charges not covered by my health benefits. It is my responsibility to notify the organizations of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill if the submitted claims or any part of them are denied for payment. I accept financial responsibility for payment for all services or products received.

Organization/Provider: MID-CITIES DERMATOLOGY CLINIC

Patient/Guardian Signature: _____ **Date:** _____

Medicare Lifetime Assignment of Benefits

I request that payment of authorized Medicare benefits be made on my behalf to Mid-Cities Dermatology Clinic for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient/Guardian Signature: _____ **Date:** _____

Medigap (Medicare supplemental insurance) Assignment of Benefits

I request payment of authorized Medigap benefits be made to this same provider and also authorize any holder of medical information about me to release to the Medigap insurer information needed to determine benefits payable for services from this provider.

Patient/Guardian Signature: _____ **Date:** _____

Release of Information to Someone OTHER THAN MYSELF

I authorize Mid-Cities Dermatology Clinic to release medical, appointment, and/or financial information over the telephone and/or to release copies of my medical records to the following person.

Name: _____ **Relationship:** _____

Social SecurityNumber: _____ - _____ - _____ **(Required for identification purposes)**
(or password)

Patient/Guardian Signature: _____ **Date:** _____

Patient Name _____

Consent to Treat

I authorize medical treatment to be performed on me at the direction of the physicians at Mid-Cities Dermatology Clinic.

Signature: _____ **Date:** _____