Skin Center of South Miami

PAYMENT & INSURANCE AUTHORIZATION FORM

DATE: _____

NAME: _____
First Middle Last

I hereby authorize payment directly to *Skin Center of South Miami* of all benefits applicable and otherwise payable to me from my insurance carrier, Medicare/Medigap, HMO, or any other third party payor for service rendered to me. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits. Medicare assigned benefits will be accepted as applicable, however, co-insurance, deductibles, and non-covered services are the financial responsibility of the patient. If there is no insurance coverage, all office fees are payable at the time service is rendered.

- You are encouraged to contact your insurance plan directly prior to services being rendered if you have any questions regarding this/these service(s).

It is the patient's responsibility to obtain verification of their insurance plan benefits. **Verbal or On-Line verification is NOT a guarantee of payment**. Services are subject to the limitations and exclusions including pre-existing conditions as stated in the insurance benefit plan.

I understand that in the event my insurance determines a service does not meet their definition of medical necessity or is considered a non-covered service due to plan exclusions and limitations including pre-existing conditions, **I will be financially responsible for payment of the service.**

(Patient's/Guardian's Signature) _____
If Patient is a minor, please provide guardian's information
Name _____ SSN _____ Date of Birth _____

MEDICARE ONLY
Authorization to Assign Medicare Benefits to Physician

(Patient's Signature) _____

For Office Use Only
Witness Signature: _____