Associated Skin Care Specialists

BOARD CERTIFIED DERMATOLOGISTS

Authorization to Bill Insurance

Assignment of Benefits: I request that payment of authorized Medicare, Medicaid, insurance, or health plan benefits be made on my behalf to Associated Skin Care Specialists P.A., for any services furnished to me by or in ASCS. I authorize any holder of medical or other information about me to release to such payer or their agents any information needed to determine these benefits for related services. I agree that my insurance can be billed for Workers Compensation visits that are determined not payable by Workman's Compensation. I agree to pay for any charges not covered by any third party payer. I understand that medical insurance policies are an arrangement between an insurance carrier and me. I understand that charges for some services may be more than what some insurance companies choose to call "usual and customary" and that unless I am covered by and in compliance with a health plan with which ASCS has a participation agreement to provide covered services, I am responsible for all charges applied to my account. In the event that a minor patient presented by someone other than the responsible party, the person who brought the minor will be accountable for charges incurred (except those covered by insurances).

Signature Patient/Other: _____Date:_____

Print Name: _____Relationship to Patient: _____

9/24/2015 This will expire in one year from date of signature unless revoked in writing by the patient or guardian.