BRANDON DERMATOLOGY, PA

Statement of Financial Responsibility & Release of Information

1. Payment and Release of Information:
I hereby assume responsibility to pay to the costs of all services provided by Brandon Dermatology, P.A. and its physician(s) to the patient. My signature below signifies my understanding and willingness to comply with this policy. All payments are due at the time services are rendered unless prior arrangements have been made. There will be a $25 charge for all returned checks. I agree I may be charged a 1.5% interest rate per month and collection fees on any unpaid balances for which I am responsible. I understand that I have a right to have prescriptions filled at the pharmacy of my choosing.

Name of patient____________________ Signature of patient__________________________________

Name of parent/guardian______________________ Signature of parent/guardian__________________

Date_______________

2. Insurance:
I understand that Brandon Dermatology, P.A. and its physician(s) will assist me in submitting my claim to my insurance carrier. I hereby authorize payment directly to Brandon Dermatology, P.A. and its physician(s) of medical benefits, for the services provided. I understand that I am financially responsible for my health **insurance deductibles, coinsurance, and non-covered services.** I also understand that I am responsible for all necessary referrals if indicated by my insurance plan.

Name of patient____________________ Signature of patient________________________

Name of parent/guardian_________________ Signature of parent/guardian_______________________

Date_______________

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MEDICARE ONLY

Lifetime Authorization:
I Certify that the information given by me in applying for payment under Title XVIII and/or Title, of the Social Security Act is correct, and request that said payment of authorized benefits are made on my behalf. I understand that I am financially responsible for my health insurance deductible, coinsurance, and non-covered services. I authorize any holder of medical or other information about me to release to the Social Security Administration or it's intermediary carriers, any information needed for their or related Medicare claim. I hereby irrevocably assign payment to Brandon Dermatology and its physician(s) accepting assignment of all medical benefits applicable and otherwise payable to me. I also understand that Medicare will cover 80% of covered charges and I will be responsible for the other 20% unless covered by an additional insurance.

Signature as it appears on card____________________________________ Date_________________

If you have a supplemental policy we are required to keep a separate signature on file:

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

Signature as it appears on card_____________________________________ Date_________________