SUSONG DERMATOLOGY

ONE TIME AUTHORIZATION FORM

www.susongderm.com

Patient's Name: _____ _____ Date _____
(Please Print) Date of Birth

Assumption of Responsibility: I agree that in consideration of services to be rendered, I obligate myself, assume financial responsibility and agree to pay upon demand to above named practice all charges for such services and incidentals incurred. Should the account be referred to an attorney for collection, I shall pay reasonable attorney fees and collection expenses. Even though insurance may be filed, I understand all bills are payable upon receipt and that I and not the insurance company, am responsible for the payment of all services.

Initial: _____

Responsibility for Co-Pay Amounts: I agree to be fully responsible for paying co-pays of set amounts at the time of my visit. Further, I understand that if my co-pay is a percentage, I will be responsible for payment immediately after insurance benefits have paid. This meaning that any bill received once insurance is paid, will be due upon receipt.

Initial: _____

Assumption of Referrals: I understand that if I have insurance coverage which requires a referral, it must be received in order to receive the maximum benefits from the insurance company. I further understand that it is my responsibility to obtain a hardcopy referral from my insurance company. I have been given the opportunity by the above named practice to obtain a referral or reschedule my appointment. I understand that if I refuse that I am taking full responsibility for payment.

Initial: _____

Assignment of Insurance Benefits: I hereby assign direct payment of any hospital insurance benefits, medical insurance benefits including Medicare, Medigap, major medical benefits, insurance disability benefits or injury benefits payable because of liability of a third party or organization, and so forth, payable to or for the above said patient until account is paid in full.

Initial: _____

MEDICARE PATIENTS ONLY – REQUIRED SIGNATURE

NAME AS IT APPEARS ON MEDICARE CARD _____

MEDICARE NUMBER _____

PLEASE SIGN SO WE MAY HAVE YOUR MEDICARE AUTHORIZATION ON FILE:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services 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: _____ Date: _____

CANCELLATION / MISSED APPOINTMENT POLICY:

If you must cancel an appointment, please call at least 24 hours in advance. Absent a compelling reason, missed appointments may be charged $50 for an office visit and $100 for a surgical visit. No further appointments will be scheduled until this no-show fee has been reconciled. Visit our website at www.susongderm.com for our complete Cancellation and Missed Appointment Policy.

Initial: _____