□ BELLM □ LYN
□ HB □ VS
□ KIM

ATLANTIC DERMATOLOGIC ASSOCIATES, LLP
INSURANCE INFORMATION

Primary Insurance Company_____

Name of Insured_____ **DOB**_____ **SSN#**_____

Relationship to Patient _____ **ID #**_____

Group #_____ **Employer:**_____

Address_____

Secondary Insurance Company_____

Name of Insured_____ **DOB**_____ **SSN#**_____

Relationship to Patient _____ **ID #**_____

Group #_____ **Employer:**_____

Address_____

MEDICARE PATIENTS: SIGNATURE ON FILE. I request and authorize payments of Medicare benefits be made to Atlantic Dermatologic Associates, LLP for any services furnished me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Service and its agents any information needed to adjudicate these benefits for services. I understand my signature requests that payment be made and authorizes release of all information necessary to adjudicate the claim. I permit a copy of this authorization to be used in place of the original. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and that I am responsible for the deductible, co-insurance, and any non-covered services.
Signature_____Date_____

ASSIGNMENT OF INSURANCE BENEFITS. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Atlantic Dermatologic Associates, LLP. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not the charges are paid by said insurance. I hereby authorize said assignee to release all information necessary to adjudicate all claims and secure payment for services rendered.
Signature_____ Date_____

Our Policy: Payment is due at the time of service. You are responsible for co-payments, coinsurance and deductibles. If your plan requires a referral it is your responsibility to provide it. There will be a fee of $20 for each check returned to us by your bank. After 3 billing statements, any unpaid balances will be forwarded to a collection agency.

Please provide us with 24 hours notice for cancellation of appointments. Too many missed appointments will result in termination from the practice.

I have read, understood and agree to be bound by the terms of this policy. To the best of my knowledge the insurance information provided above is correct.

Signature_____ Date_____