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**CONSENT AND AUTHORIZATION OF DERMATOLOGY CENTER**

NAME OF PATIENT \_\_\_\_\_ SS# \_\_\_\_\_ DATE \_\_\_\_\_

**Authorization to Release and Obtain Medical Records**

I hereby authorize the Dermatology Center to release and/or obtain all information, records, treatment notes or test. I authorize the release of any information to any concerned third party payer.

Patient/Guardian Signature X \_\_\_\_\_ Date \_\_\_\_\_

**Financial Agreement**

The undersigned understand, whether signed as an agent or as a patient, that in consideration of the services to be rendered to the patient, they are obligated and directly financially responsible to pay the amount of all charges incurred for services and procedures rendered at the Office of Dermatology Center, regardless of insurance coverage or lien. The agree to pay any legal interest, collection expense and attorneys fees incurred, should it become necessary to assign any amount that may be owed for collection.

Patient/Guardian Signature X \_\_\_\_\_ Date \_\_\_\_\_

**Authorization to Assignment of Benefits**

I hereby assign and authorize all payments and/or insurance benefits for medical services and/or surgical procedure rendered to the patient, directly to Dermatology Center. I hereby authorize said assignee to release all information to secure payments. I understand that I am financially responsible for all charges not covered by this agreement.

Patient/Guardian Signature X \_\_\_\_\_ Date \_\_\_\_\_

**Child Custody Cases**

The parent with primary custody is usually the parent with whom the child lives and who usually brings the child to the clinic for care. The custodial parent is responsible for payment at the time of service whether the account is considered self-pay, participating insurance, or nonparticipating insurance. If the non custodial parent carries the insurance on the child, the clinic will bill that insurance company. The clinic does not get involved with divorce specifics, e.g., one parent pays 80% and the other pays 20%. It is the parent's obligation to work out an agreement themselves or through the court system.

Parent/Guardian Signature X \_\_\_\_\_ Date \_\_\_\_\_

**Medicare Authorization**

I request the payment of authorized Medicare benefits be made on my behalf to the Dermatology Center for any services furnished to me by them. I authorize any holder of medical information about me, to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits payable for related services.

Patient/Guardian Signature X \_\_\_\_\_ Date \_\_\_\_\_

I hereby certify that all statements given to the Dermatology Center and Staff are complete and accurate to the best of my knowledge. A copy of this agreement should be considered as effective and valid as the original.

Patient/Guardian Signature X \_\_\_\_\_ Date \_\_\_\_\_  
 Guarantor Relationship X \_\_\_\_\_  
 Witness Signature X \_\_\_\_\_ Date \_\_\_\_\_

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Diseases, Surgery & Laser of the Skin, Hair & Nails