

# SOUTHEASTERN DERMATOLOGY, P.A.

NAME \_\_\_\_\_ CHART NO. \_\_\_\_\_  
(Last) (First) (Middle)

## Primary Insurance To File

Insurance Company Name \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured's Social Security # or ID # \_\_\_\_\_

## Secondary Insurance To File

Insurance Company Name \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured's Social Security # or ID # \_\_\_\_\_

I authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Credit information is required for check acceptance and special pre-arranged billing situations.

Driver's License # \_\_\_\_\_ State of Issue \_\_\_\_\_

M.C. # \_\_\_\_\_ Expiration Date \_\_\_\_\_

Visa # \_\_\_\_\_ Expiration Date \_\_\_\_\_

Name as it appears on card \_\_\_\_\_

Cardholder Signature \_\_\_\_\_ Date \_\_\_\_\_

**Payment is required for all services at the time they are rendered.** We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be preverified and you will be asked to pay any unmet deductible, non-covered services and copayments. Your signature below signifies your understanding and willingness to comply with this policy.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

# SOUTHEASTERN DERMATOLOGY, P.A.

NAME \_\_\_\_\_ CHART NO. \_\_\_\_\_  
(Last) (First) (Middle)

## INSURANCE FOR COPYING PURPOSES, PLEASE GIVE YOUR CARD(S) TO THE RECEPTIONIST

Medicare No. \_\_\_\_\_

Medicaid No. \_\_\_\_\_

Other Insurance \_\_\_\_\_

(Insurance Company)

(Certificate Number)

(Group Number)

(Policy Holder)

(Relationship to Patient)

Other Insurance \_\_\_\_\_

(Insurance Company)

(Certificate Number)

(Group Number)

(Policy Holder)

(Relationship to Patient)

## Medicare Patient Information

Please read each of the following and answer as they apply to you. If it does apply to you, please check YES. If it does NOT apply to you, please check NO.

YES NO

- Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?
- Are you covered by a HMO/PPO which makes Medicare secondary?
- Do you have Medicaid?
- Are you coming to this office for an illness or accident that has been covered or is authorized for coverage from the VA (Veteran's Administration)?
- Are you eligible for any benefits under the Federal Black Lung Program?
- Are you coming to this office for an illness, accident or injury that is the result of an automobile accident?
- Are you coming to this office due to Medicare disability coverage?
- Are you covered by the Federal End Stage Renal Disease Program?
- Are you presently receiving Workers' Compensation?
- Is the illness or injury you are coming to this office for the result of work-related causes?

### 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 Health Care Financing Administration 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.

Date \_\_\_\_\_ Signature \_\_\_\_\_

In the event of a major procedure or hospitalization, we request secondary insurance information for our records (supplemental Medicare insurance). Please fill out below if you are covered by a plan which covers the 20% NOT covered by Medicare (Medigap Coverage).

### Please sign so we may have your Supplemental authorization 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 to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Date \_\_\_\_\_ Signature \_\_\_\_\_