Florida Dermatology AND SKIN CANCER CENTERS

ASSIGNMENT OF BENEFITS
(MEDICARE AND COMMERCIAL GROUP INS)

I, _____(LAST NAME, FIRST NAME)

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organization listed below for any equipment or services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

SIGNATURE: _____DATE:_____

[ ] PATIENT [ ] GUARDIAN: LIST RELATIONSHIP _____

IF PAYMENT IS NOT MADE BY THE INSURANCE COMPANY FOR THE SERVICES, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR THE PAYMENT OF THE SERVICES PROVIDED ON MY BEHALF IN FULL. (CFDSCC is a Medicare participating provider and as such accepts the allowable that Medicare assigns to the item as payment in full and will not bill the patient more than his/her deductible or copay (20%) amounts.)

SIGNATURE: _____DATE:_____

[ ] PATIENT [ ] GUARDIAN: LIST RELATIONSHIP _____