



Consent and File

Patient: _____ **Parent/Guardian:** _____

Information: Do you have insurance? Yes No Do you have Medicaid? Yes No
Primary Insurance carrier: _____ Policy Holder: Self Other (answer below)
Secondary Insurance carrier: _____ Policy Holder: Self Other (answer below)

Policy holder's information (if other than patient):

Name: _____ Jr. Sr.
First Middle Last
Date of Birth: ____ / ____ / ____ Sex: M F Social Security # _____
Relationship to patient: _____ Employer: _____

Release of Medical Information

I hereby authorize the physician involved with my (named patient) care to release information from my (their) medical record as may be required to any person, corporation, or agency which is legally responsible or has good cause to believe is legally responsible for processing and/or paying all or any part of the physicians charges and/or professional fees; to any entities designated by me for discharge and planning purposes.

Medicare Consent (If applicable)

I certify that the information given by me in applying for payment under title XVIII (Medicare) of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. The Medicare intermediary advises that the type of services may no longer qualify as covered under Medicare.

Assignment of Benefits/Financial

I hereby assign payment directly to Advanced Dermatology of Northern Indiana, P.C. all insurance benefit payments (including any major medical payments) due to me as a result of the named patient's outpatient treatment or service and pursuant to any insurance contract I have which provides for such treatment. I agree to be responsible for any charges incurred that are not paid by insurance or other third party payors.

** I agree co-insurance or deductible amounts are my responsibility. I also acknowledge that the filing of insurance claims is NOT a guarantee of payment, and that I am financially responsible for payment if such claims are unpaid. I understand there is a \$25.00 fee for returned checks and any and all collection fees or attorney fees as a result of delinquent payment will be my responsibility.** I understand laboratory and/or pathology fees are associated with some procedures and agree to pay these to the appropriate facilities including outside pathology facilities.

I understand medicine is a service business and not keeping appointments adversely affects medical care. I accept the practice reserves the right to charge \$35 for appointments cancelled with less than 24 hours notice or not kept by me (no show).

By signing this document, I acknowledge that I have read and understand this consent. Further, I hereby consent and authorize this facility to use or disclose my Protected Health Information in conjunction with Treatment, Payment or Health Care Operations in accordance with the terms of this consent.

Signature: _____ **Date:** _____

Circle: Patient/ Legal Guardian/ POA

Please present your insurance card(s) and your photo identification to the receptionist. The receptionist will make a copy and return them to you promptly. Co-pays and previous balances are due at check-in. Thank you.