The Skin Surgery Center, PA and its affiliates

AUTHORIZATIONS AND CONSENTS FOR PRECERTIFICATION,
FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS AND RELEASE OF CLAIMS INFORMATION

Precertification & Financial Responsibility: I understand that it is the insurer's responsibility to review anticipated courses of treatment. I understand that if the insurer determines that the treatment plan is necessary and appropriate and issues certification, the benefits of my health plan will be available to me according to my policy terms. However, if certification is denied, benefits may be withheld. I understand that precertification may be the responsibility of the patient or financially responsible party and his or her physician. I also understand that I may be financially responsible for any and all related charges incurred as a result of this treatment plan should the insurer either refuse to pre-certify the treatment or retrospectively determine that a specific service was inappropriate, or should the certification occur too late to be valid. I understand that to protect myself from unnecessary personal financial obligations, I must review my obligations with my insurance company and personal physician in advance of my appointment.

Assignment of Benefits: In consideration of the services provided to me, I hereby assign and transfer to The Skin Surgery Center, (SSC), all medical provider benefits payable and any related rights existing under the insurance policies described (but not to exceed the amount of charges for this period of service). I authorize and direct the insurance company to pay all such benefits to SSC. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and SSC.

Authorization to Release Claims Information: I hereby authorize The Skin Surgery Center, their employees and agents to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my (or the patient's) medical care and treatment to all appropriate persons for the purpose of evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare), or any private reimbursement which may have a bearing on benefits by or on behalf of any such person. I hereby authorize SSC, its employees and agents to act on my behalf in completing claims.

I HAVE READ AND FULLY UNDERSTAND THE PRECERTIFICATION & FINANCIAL RESPONSIBILITY AUTHORIZATIONS, ASSIGNMENT OF BENEFITS CONSENTS AND AUTHORIZATION TO RELEASE CLAIM INFORMATION PRINTED ON THIS FORM AND FULLY ACCEPT AND CONSENT TO EACH OF THEM. THIS INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Patient's Signature: ____ Date: ______/________/_________

Patient's Printed Name: ____

I am legally authorized to provide consent on behalf of the patient listed above. My relationship to the patient is as follows:

Signature of Authorized Representative: ____

Relationship to Patient: ____ Date: _______/_________/__________

Witness: ____ Date: _______/_________/__________