



**INSURANCE ASSIGNMENT**

**TREATMENT, FINANCIAL RESPONSIBILITY STATEMENT**

- A. I hereby request evaluation and treatment by a physician of PANZER DERMATOLOGY ASSOCIATES, P.A. and/or their assistants.
- B. I understand that my insurer may not pay for all services provided by PANZER DERMATOLOGY ASSOCIATES, P.A. I understand I am responsible for co-pays and deductibles (at the time of service) and I am also aware that my insurer may have limitations, restrictions and authorization/referral requirements on services rendered. If my insurer denies coverage of any services, I (patient, guarantor) accept full responsibility for payment of those services.
- C. I realize that failure to keep this account current will result in a \$5.00 re-billing charge.
- D. I understand that failure to give 24 hours notice of appointment cancellation will result in a \$20.00 charge.
- E. For all services rendered to minor patients, the adult accompanying the patient is responsible for any payment due at the time of service.
- F. I authorize payment of medical benefits for myself/dependent directly to PANZER DERMATOLOGY ASSOCIATES, P.A. for professional services.
- G. I authorize the release of medical information necessary to process insurance claims.

**X** \_\_\_\_\_  
(Signature of patient **OR** Responsible Party if a Minor) (Date)

**FOR MEDICARE PATIENTS ONLY:**

**Please sign below once or twice as applicable. You may complete insurance information or give cards to the receptionist to complete.**

I request that payment of authorized **Medicare** and/or insurance benefits be made either to me or on my behalf to PANZER DERMATOLOGY ASSOCIATES, P.A. , for any services furnished me by said physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine the benefits payable for related services.

**X** \_\_\_\_\_ (SIGNATURE OF BENEFICIARY) \_\_\_\_\_ (HIC CLAIM NUMBER)  
\_\_\_\_\_  
(DATE)

**SECONDARY INSURANCE FOR MEDICARE PATIENTS**

I request that payment of authorized **Medigap** benefits be made either to me or on my behalf to PANZER DERMATOLOGY ASSOCIATES, P.A. I authorize any holder of medical information about me to release to (below named **Medigap** insurer) any information needed to determine the benefits payable for related services.

**X** \_\_\_\_\_ (SIGNATURE OF BENEFICIARY)  
\_\_\_\_\_  
(MEDIGAP CARRIER)  
\_\_\_\_\_  
(MEDIGAP ADDRESS)  
\_\_\_\_\_  
(MEDIGAP POLICY NUMBER)  
\_\_\_\_\_  
(MEDIGAP POLICY HOLDER)