This section for Medicare Beneficiaries only

This office is required to keep your signature on file authorizing us to file claims so Medicare for you and to release information to that payor if they required it for proper consideration of a claim.
Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to Social Security Administration and Centers for Medicare and Medical Services (CMS) 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.

_________________________________ _________________
Signature as it appears on Medicare card Date

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically “crosses over”, we are required to keep a separate signature on file:

_________________________________ _________________
Signature as it appears on Medicare card Date

NON-COVERED ROUTINE SERVICES

AS YOUR HEALTH CARE PROVIDER, I WANT TO PROVIDE YOU WIT THE BEST POSSIBLE CARE. THERE MAY BE CERTAIN ROUTINE SERVICES THAT I FEEL ARE NECESSARY FOR THE MAINTENANCE OF YOUR GOOD HEALTH THAT ARE NOT COVERED BY YOUR HEALTH INSURANCE CONTRACT. THESE MAY INCLUDE BUT NOT BE LIMITED TO LAB PROCEDURES, PATHOLOGY SERVICES, INJECTIONS, OR INTRALESIONAL INJECTIONS

By signing below, you accept the responsibility for any cost not covered by your insurance and agree to the financial policy of Heights Dermatology.

Patient Name (please print) ____

Signature ____Date ___/___ /___

PLEASE PRESENT YOUR INSURANCE CARDS AND YOUR PHOTO ID TO THE RECEPTIONIST

AUTHORIZATION OF DISCLOSURE

DESIGNATED PERSONS AUTHORIZED TO RECEIVE MY PERSONAL HEALTH INFORMATION

Please list anyone it is okay for us to discuss your personal health information with:

NAME	RELATION	PHONE NUMBER

Patient Signature: ____

AUTHORIZED METHODS OF COMMUNICATION (CHECK ALL THAT APPLY)			
HOME #	WORK #	CELL #	WRITTEN CORESPONDENCE
___ Do not contact at this number	___ Do not contactat this Number	___ Do not contact at this number	__Mail/Delivery Service
__ Leave call back number only; do not leave message	_ Leave call back number only; do not leave message	_ Leave call back number only; do not leave message	__ Fax: _____________
___ Okay to leave detailed message with person	___ Okay to leave detailed message with person	___ Okay to leave detailed message with person	___ Email @ residence Address:
___ Okay to leave detailed message on answering machine	____Oka to leave detailed message on personal voice mail	___ Okay to leave detailed message on voice mail	___ Email @ work Address:

PRIVACY POLICY WRITTEN ACKNOWLEDGMENT

I AM A PATIENT OF HEIGHTS DERMATOLOGY, DR. RETNA A. BILLANO
I HEREBY ACKNOWLEDGE RECEIPT OF NOTICE OF PRIVACY PRACTICE.

NAME (PLEASE PRINT) ____

SIGNATURE ____

DATE____

OR

I AM A PARENT OR LEGAL GUARDIAN OF _______________________________(PATIENT NAME)
I HEREBY ACKNOWLEDGE RECEIPT OF HEIGHTS DERMATOLOGY, DR. RETNA A. BILLANO NOTICE OF PRIVACY PRACTICES WITH RESPECT TO THE PATIENT.

NAME: ____

SIGNATURE: ____

RELATIONSHIP TO PATIENT: _______________________________________