Escondido Dermatology Inc. 504 W. Mission Avenue, Suite 101 Escondido, CA 92025
(760) 747-1980 (760) 747-2045 Fax

MEDICARE PATIENTS

We are required to keep your signature on file authorizing us to file claims to Medicare and any supplemental Medigap insurance to which Medicare automatically sends claims for you and to release information that the payer requires for proper consideration of a claim. Please read and sign the following statement:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Escondido Dermatology Inc. for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicted in Item 9 of the HCFA-1500 claim form or electronically submitted claims, my signature authorizes releasing of the information to insurer or agency shown. In Medicare-assigned cases the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

______________________________________ ______________

Signature as it appears on Medicare Card **Date**

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Printed Name

MEDIGAP SUPPLEMENTAL INSURANCE

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Escondido Dermatology Inc. for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to any information need to determine these benefits or the benefits payable for related services.

______________________________________ ______________

Signature **Date**

CANCER POLICY PATIENTS

I authorize Escondido Dermatology Inc. to release any information needed to determine benefits to my cancer insurance company.

______________________________________ ______________

Signature **Date**

ESCONDIDO DERMATOLOGY, INC.