911 North Plum Grove Rd Suite A
Schaumburg Dermatology, IL 60173

INSURANCE POLICY

I hereby authorize this physician to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct, I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, (or in the case of Medicare part B benefits to the social security administration and healthcare financing administration).

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to this physician for services rendered. I further authorize the release of any information needed for processing of my insurance claims.

A copy of this authorization may be used in the place of the original.

I understand and agree that I am financially responsible for all charges not paid by my insurance company.

This authorization may be revoked by either me or my insurance carrier at any time in writing.

Patient or Responsible Party Signature _____

Date ____/_____/_____