

# SKIN AND CANCER ASSOCIATES

## Insurance Assignment Agreement/Privacy Notice Acknowledgment

**\*\*PLEASE SIGN THE RELEASE(S) BELOW THAT PERTAINS TO YOUR TYPE(S) OF INSURANCE\*\***

### COMMERCIAL INSURANCE

I, the undersigned, certify that I (or my dependent) have insurance coverage through \_\_\_\_\_

\_\_\_\_\_, and assign directly to Skin and Cancer Associates (SCA) all  
Name of Insurance Company(ies)

insurance benefits, if any, otherwise payable to me, for services rendered. I hereby authorize SCA to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. **I understand that I am responsible for my health insurance deductibles and coinsurance.**

\_\_\_\_\_  
Beneficiary/Patient Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

**MEDICARE and/or MEDICAID** *Lifetime Authorization. Medicare and Medicaid patient certification. Patient certification authorization to release information and payment request.*

I certify that the information given by me in applying for payment under Title XVIII and or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. **I understand that I am responsible for my health insurance deductibles and coinsurance.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date

**MEDIGAP** NOTE: IF YOU SIGN HERE YOU SHOULD ALSO SIGN FOR MEDICARE ABOVE.

*Beneficiary Signature Authorization.*

I request that payment of authorized Medigap benefits be made on my behalf to SCA for services furnished to me by the physician(s) of SCA. I authorize any holder of medical information about me to release to my Medigap carrier any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
Beneficiary/Patient Signature

\_\_\_\_\_  
Print Beneficiary/Patient Name

\_\_\_\_\_  
HIC (Medicare) Number

\_\_\_\_\_  
Medigap Number

\_\_\_\_\_  
Name of Medigap Insurance Company

\_\_\_\_\_  
Date

### PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Authorized representative (if applicable)