AUTHORIZATION TO RELEASE MEDICAL BENEFITS

I authorize the release of all medical information necessary to process insurance claim(s) and I hereby assign and authorize direct payment of all medial and/or surgical benefits, including major medical, private insurance, and other health plans to the undersigned.

Dermatology & Skin Cancer Center
T.J. Giuffrida, M.D., P.A. • Coral Gables, FL

Please remember that medical insurance is considered a method of deferred payment and is not a substitution for payment. It is your responsibility to pay any deductible amount, co-insurance or any other balance deemed patient responsibility by the insurance company. It is your responsibility to pay the balance in full if the insurance information you provide proves false or otherwise ineffective. It is your responsibility to follow all guidelines of your insurance company, including obtaining referrals as necessary if your coverage is through an HMO. You must inform our office prior to receiving service if your insurance coverage is through an HMO. Information regarding any change in your insurance coverage must be provided prior to receiving service. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.
To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record to the patient's insurance company.
This Assignment will remain in effect until revoked by me in writing. A signed photocopy of this Assignment is to be considered as valid as an original.

Signature of Patient
______________________________________Date______________________________

Signature of Responsible Party
______________________________________Date______________________________

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized benefits be made on my behalf to T.J. Giuffrida, M.D., P.A., Dr. Giuffrida, or to his associates for any services furnished to me by that physician. 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 those benefits or the benefits payable for related services.

Signature of Beneficiary
_________________________________Date______________________________

LIFETIME CONSENT

I request that payment of authorized Medigap benefits be made on my behalf to Dr. Giuffrida or to his associates for any services furnished to me. 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 or the benefits payable for related services.

Signature of Beneficiary
_________________________________Date______________________________
Medigap Insurer
_______________________________________Patient'sMedigap#________________