2021 Medical Insurance Information

FOR MEDICAL INSURANCE PATIENTS ONLY

Our offices do not take all insurance plans. If you are expecting to use your insurance, please verify coverage with your insurance company and determine that we ae under your primary plan. If we do not take your primary insurance, you will be seen as a self pay patient and can bill your insurance yourself for the visit. We do not courtesy bill, nor do we have any control over whether or not your insurance will reimburse you or the amount of possible payment.

NAME OF PRIMARY INSURED____
Last Name First Name Middle Initial

Primary Insured SS# ________________________ Primary Insured Birthdate____/____/_____

Badge # if METRO __________________________

PRIMARY INSURANCE (Please give copy of ID & card to receptionist for billing)

___________________________________ ____________________ ____________________
Insurance Company Group # Policy #

NAME OF SECONDARY INSURED____
Last Name First Name Middle Initial

Secondary Insured SS# ______________________ Secondary Insured Birthdate____/____/____

Badge # if METRO __________________________

SECONDARY INSURANCE (Please give copy of ID & card to receptionist for billing)

___________________________________ ____________________ ____________________
Insurance Company Group # Policy #

Notice and Authorization of Medical Information

I, the undersigned, certify that I (or my spouse or dependent) have insurance coverage with the above listed insurance company(ies) and assign directly to Lakes Dermatology all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am responsible for all charges whether or not paid by insurance and will be billed for my deductible, co-insurance, or other expenses stated by my insurance policy.** Should I receive payment due to Lakes Dermatology from my insurance (i.e., some insurance companies remit payment to the insured to remit to the provider), I state that I will send this payment of monies to Lakes Dermatology. I hereby authorize the doctor to release all information necessary for purposes of treatment, payment, and conducting day-to-day operations and that the medical practice does not require my authorization. I authorize the use of this signature on all insurance submissions.

____ Date _____/______/_______

Patient (or Guardian) Signature