Lakes Dermatology & Laser Center

# 2024 Medical Insurance Information

THE SPA AT LAKES DERMATOLOGY

## 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.

Our staff has no way of knowing what deductible or co-insurance balances may be due from you. Any office visit, procedure, or surgery in our office may be applied to your deductible or co-insurance. **There is always a chance you will receive a bill from us even when you pay your co-payment at the time of service. We accept payments plans and are always willing to work with you when needed.** If you do not understand how your insurance works or your benefits, please contact your insurance to discuss. We cannot see these benefits or have any influence on what your insurance pays or determines that you owe.

NAME OF PRIMARY INSURED_____
Last Name First Name Middle Initial

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

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____/____/_____

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 office to release all information necessary for purposes of treatment, payment, and conducting day-to-day operations. I authorize the use of this signature on all insurance submissions.

_____ Date _____/_____/_____
Patient (or Guardian) Signature