LIFETIME INSURANCE AUTHORIZATION

This form gives permission to submit claims to your insurance carrier.
All patients with health insurance must complete this form.

Name of Patient: _____

Patient Date of Birth: _____/_____/_____

I authorize the release of any medical information to process any insurance claims relating to past, present, or future medical examinations, tests, treatments, or other services rendered by Georgetown Dermatologists, PC, Christopher J. Remishofsky, MD, or any other person employed by Georgetown Dermatologists, PC.

I authorize payment of medical or other benefits for all such services to be paid to Georgetown Dermatologists, PC.

If my medical insurance company does not pay for such services within 60 days after services were rendered, for any reason, including the reason of no medical necessity, then I promise to pay Georgetown Dermatologists, PC for such services.

I request that payment of authorized Medicare benefits, or any other health insurance or managed care plan, be made on my behalf to Georgetown Dermatologists, PC for any services furnished me by any person employed by Georgetown Dermatologists, PC. I authorize the holder of medical information about me to release to the Centers for Medicare and Medicaid services (CMS) and its agents, or any other health insurance company or managed care plan that I have, any information needed to determine these benefits for related services.

Patient's Signature: _____ Date: _____/_____/_____

Parent/Guardian Signature: _____

FOR PATIENTS WITH NO INSURANCE:

I will be personally responsible for full payment of medical care at the time service is rendered.

Patient's Signature: _____ Date: _____/_____/_____

Parent/Guardian Signature: _____