Skin Care Physicians
OF FAIRFIELD COUNTY
Adult & Pediatric Dermatology

GAIL B. WHITMAN, M.D.
Diplomate of The
American Board of Dermatology

DENISE GALLO, A.P.R.N

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished to me by the listed provider/supplier. 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 their benefits payable for related services.

I understand my signature requests that payments be made and authorize release of medical information necessary, to pay the claim. If "other health insurance" is indicated in *Item 9 of the HCFA-1500 Form*, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown, In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the **patient is responsible only for the deductible, or co-insurance, and non-covered services**. Coinsurance and the deductible are based upon the charge determination of Medicare carrier.

Medicare requires a written statement by the Medicare patient before a physician furnishes services that may be excluded from coverage by Medicare as not responsible or necessary.

This statement is to show that I have been informed of the possible non-coverage of the services and that there will be a charge for the services to me from SkinCare Physicians of Fairfield County, separate from Medicare, if the services are non-covered.

_____
Patient's Name (please print)

_____
Patient's Signature

_____
Date Signed

Updated 6/2014