Tina Snodgrass Skin Care Practice, PLLC

INSURANCE INFORMATION

Print Patient Name:____DOB:__________________________

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Primary Insurance: **ID#:**

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Card Holder's Name: **Card Holder's DOB:** **Relationship to Patient:**

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Secondary Insurance: **ID#:** **Card Holder's Name:** **Card Holder's DOB:**

Please initial all that apply:

_____ I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize Tina Snodgrass Skin Care Practice, PLLC to release to the Social Security Administration or its intermediaries of carriers any information needed for this or related Medicare, or secondary claims. I request that payment of assigned benefits be made in my behalf to my provider at Tina Snodgrass Skin Care Practice, PLLC and that her office may submit claims for all medical services rendered to me. My signature below represents authority for all claims made in my behalf without signing each claim.

_____ I undersigned certify that I have coverage with the insurance carrier whose name I provided to the office, Tina Snodgrass Skin Care Practice, PLLC. I authorize Tina Snodgrass Skin Care Practice, PLLC to submit all claims for services on my behalf without signing each claim and to accept assigned benefits for her services. I understand that I am financially responsible for all charges that are not covered by my insurer and that I am responsible for obtaining current referrals for services when applicable.

_____ I certify that I do not have any forms of Insurance. I understand payments are due at time of service, unless prior arrangements have been approved.

By signing my name below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of and agreement with the policies. You may receive a copy of this document upon request.

____
Patient/Guardian Signature Date

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Relationship to patient (if applicable)