SOUTHEASTERN DERMATOLOGY, P.A.

NAME_____ **CHART NO.**_____
(LAST) (FIRST) (MIDDLE)

PRIMARY INSURANCE TO FILE

INSURANCE COMPANY NAME_____

INSURANCE COMPANY ADDRESS_____

POLICY#_____ **GROUP#**_____

INSURED'S NAME_____ **RELATIONSHIP TO PATIENT**_____

INSURED'S SOCIAL SECURITY# OR ID#_____

SECONDARY INSURANCE TO FILE

INSURANCE COMPANY NAME_____

INSURANCE COMPANY ADDRESS_____

POLICY#_____ **GROUP#**_____

INSURED'S NAME_____ **RELATIONSHIP TO PATIENT**_____

INSURED'S SOCIAL SECURITY# OR ID#_____

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN.

SIGNATURE_____ **DATE**_____

CREDIT INFORMATION IS REQUIRED FOR CHECK ACCEPTANCE AND SPECIAL PRE-ARRANGED BILLING SITUATIONS.

DRIVER'S LICENSE #_____ **STATE OF ISSUE** _____

M.C. #_____ **EXPIRATION DATE** _____

VISA #_____ **EXPIRATION DATE**_____

NAME AS IT APPEARS ON CARD_____

CARDHOLDER SIGNATURE_____ **DATE** _____

PAYMENT IS REQUIRED FOR ALL SERVICES AT THE TIME THEY ARE RENDERED. WE ACCEPT PAYMENT IN THE FORM OF CASH, CHECK, OR CREDIT CARD. IN THE EVENT OF HOSPITALIZATION OR MAJOR PROCEDURES, OUR OFFICE WILL FILE APPROPRIATE INSURANCE. HOWEVER, BEFORE SUCH CLAIMS ARE FILED, COVERAGE WILL BE PREVERIFIED AND YOU WILL BE ASKED TO PAY ANY UNMET DEDUCTIBLE, NON-COVERED SERVICES AND COPAYMENTS. YOUR SIGNATURE BELOW SIGNIFIES YOUR UNDERSTANDING AND WILLINGNESS TO COMPLY WITH THIS POLICY.

PATIENT SIGNATURE_____ **DATE** _____