SKIN AND CANCER ASSOCIATES

Insurance Assignment Agreement/Privacy Notice Acknowledgment

PLEASE SIGN THE RELEASE(S) BELOW THAT PERTAINS TO YOUR TYPE(S) OF INSURANCE

	, and assign directly to Skin	and Cancer Associates (SCA) all
Name of Insurance Company(
	efits. I authorize the use of this signature	ereby authorize SCA to release all information ure on all insurance submissions. I understand tha
Beneficiary/Patient Signature	Relationship	Date
certification authorization to release in I certify that the information given by r correct. I authorize any holder of med intermediary carriers, any information	formation and payment request. the in applying for payment under Title ical or other information about me to represent the formation about me to represent the formation and the same and the same and the same are same and the same are same as a same are same and the same are same a	Ad Medicaid patient certification. Patient XVIII and or Title XIX of the Social Security Act is elease to the Social Security Administration or its elease to the Social Security Act in the Soc
	- Dispersion N	
	Print Patient Name	Date EOP MEDICARE AROVE
MEDIGAP NOTE: IF YOU SIGN Beneficiary Signature Authorization. I request that payment of authorized M physician(s) of SCA. I authorize any honeded to determine these benefits or the second s	N HERE YOU SHOULD ALSO SIGN edigap benefits be made on my behalf to the solder of medical information about me benefits payable for related services.	FOR MEDICARE ABOVE. o SCA for services furnished to me by the to release to my Medigap carrier any information
MEDIGAP NOTE: IF YOU SIGNE Beneficiary Signature Authorization. I request that payment of authorized Menthesician(s) of SCA. I authorize any homeded to determine these benefits or the Beneficiary/Patient Signature	N HERE YOU SHOULD ALSO SIGN edigap benefits be made on my behalf to the solder of medical information about me benefits payable for related services.	FOR MEDICARE ABOVE. To SCA for services furnished to me by the to release to my Medigap carrier any information
MEDIGAP NOTE: IF YOU SIG- Beneficiary Signature Authorization. I request that payment of authorized M physician(s) of SCA. I authorize any h needed to determine these benefits or th Beneficiary/Patient Signature HIC (Medicare) Number	N HERE YOU SHOULD ALSO SIGN edigap benefits be made on my behalf to alder of medical information about me benefits payable for related services. Print Beneficia	FOR MEDICARE ABOVE. To SCA for services furnished to me by the to release to my Medigap carrier any information
Beneficiary Signature Authorization. I request that payment of authorized M physician(s) of SCA. I authorize any henceded to determine these benefits or the Beneficiary/Patient Signature HIC (Medicare) Number Name of Medigap Insurance Company PRIVACY NOTICE ACKNOWI	N HERE YOU SHOULD ALSO SIGN edigap benefits be made on my behalf to alder of medical information about me benefits payable for related services. Print Beneficia Medigap Number Date Date	FOR MEDICARE ABOVE. To SCA for services furnished to me by the to release to my Medigap carrier any information

Parent or Authorized representative (if applicable)