weissmann **mehrel**
dermatology, dermatologic surgery, mohs micrographic surgery, laser surgery, liposuction, cosmetic dermatology

PATIENT CONSENT AND AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatments, administration of anesthetics and performance of diagnostics and/or surgical procedures.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for the charges not covered by my insurance and for any and all charges which the insurance carrier declines to pay. It is further agreed that any credit balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said physician(s) by the insured or his/her family.

RELEASE OF INFORMATION: The physician(s) may disclose all or part of the patient's record to any person or corporation which may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient, including but not limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer, for the purpose of settlement of the charges for medical services. Release of information to anyone else will require specific written authorization from the patient.

I Authorize the Doctor or the staff of Weissmann and Mehrel to act on my behalf by contacting the Department of Financial Services of the State of Florida (Insurance Commissioner Office), or my insurance company in order to obtain proper payment for services I received.

H.M.O. DISCLAIMER: This office is a provider for only one HMO,UHC (United Health Care). I certify that I am not presently enrolled in any other Health Maintenance Organization (H.M.O.). Any misinformation given by me today regarding enrollment in an H.M.O. plan will constitute my financial responsibility of claim for all services received.

COLLECTION POLICY: In order to establish an optimal relationship with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR YOUR PART OF THE CHARGES. WE ACCEPT DISCOVER, VISA, MASTERCARD AND AMERICAN EXPRESS, FOR YOUR CONVENIENCE. Your signature below signifies your understanding and willingness to comply with this policy. Your signature also confirms your understanding that should this account be referred to an agency or attorney for collection, you will be responsible for all collection costs, attorney fees and court costs. **THERE IS A $25 RETURN CHECK CHARGE. THERE IS A $25 NO SHOW FEE.** (No show is not keeping your appointment without prior notice of cancellation.)

LIFETIME AUTHORIZATION
MEDICARE AND MEDICAID PATIENT CERTIFICATION - PATIENT CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUESTS: I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and co-insurance.

_____ _____

DATE **PRINT PATIENT'S NAME**

_____ _____

WITNESS **SIGNATURE OF RESPONSIBLE PATIENT**

_____

PATIENT UNABLE TO SIGN DUE TO

400 arthur godfrey road, suite #300, miami beach, fl 33140
tel. (305) 674-9009 fax. (305) 674-9014