Alysa R. Herman M.D.

Request for Confidential Communications

I,_____ authorize the staff of Dr. Herman to notify me of my diagnostic or lab results. Please check one of the options

_____ Speak with me only

_____ Leave a message at my phone number designated below if I am not available.

Home (_____) _____ Work (_____) _____

Cell (_____) _____

_____ Leave a message with anyone answering my phone.

_____ Name of other person(s) authorized to accept results for me:

- _____
- _____

Relationship: _____ Telephone (_____)_____

_____ Other

_____ Don't call me with any results. I will call the office if I want test results.

Complete address for communication

Local _____

_____

Permanent

_____

_____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

135 San Lorenzo Avenue* Suite 700 * Coral Gables, Florida 33146

*Phone: (305)444-4979 Fax: (305)444-4978

Skin and Cancer Associates

Insurance Assignment Agreement/Privacy Notice Acknowledgment

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

COMMERCIAL INSURANCE
I, the undersigned, certify that I (or my dependent) have insurance coverage through _____(Name of Insurance), and assign directly to Skin and Cancer Associates (SCA) all insurance benefits, if any, otherwise payable to me, for services rendered. I hereby authorize SCA to release all information nessesary to secure the payment of benefits. I authorize the use of this signature on all submissions.

_____ _____ _____

Insured Signature Relationship to Insured Date

MEDICARE and/or MEDICAID *Lifetime Authorization. Medicare and Medicaid patient certification. Patient Certification authorization to release information and payment request.*
I certify that the information given by me in applying for payment under Tittle 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 the authorized benefits me 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 coinsurance.

_____ _____ _____

Patient Signature Print Patients Name Date

MEDIGAP NOTE: IF YOU SIGN HERE YOU SHOULD ALSO SIGN FOR MEDICARE ABOVE

Beneficiary Signature Authorization
I request that payment of authorized Medigap benefits be made on my behalf to SCA for services furnished to me by the physician(s) of SCA. I authorize any holder of medical linformation about me to release to my Medigap carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____ _____

Insured Signature Print Beneficiary Name HIC (Medicare) number

_____ _____ _____

Medigap Number Name of Medigap Insurance Company Date

PRIVACY NOTICE ACKNOWLEDGEMENT
I acknowledge that I was provided a copy of the Notice of Privacy Practices for Skin and Cancer Associates.

_____ _____ _____

Patient Signature Print Patients Name Date

_____

Parent or Authorized representative (if applicable)