Medical Acne & Skin Care, pllc
Insurance Billing Agreement

Patient Name ________________________________Date of Birth_____________
Address____________________________________ Phone____________________
City, State, Zip____
Emergency Contact (name, phone)_______________________________________

Email (for invoicing of non-covered charges)________________________________
--Let us know if you prefer U.S. Mail for invoices

Policy holder (if different from patient)_____________________________________
--Relationship to patient: __________________ **Holder's Date of Birth**___________
--Address____
--City, State, Zip____

Release of Records for Billing and/or Payment Purposes: I hereby authorize release of any relevant medical/clinical information (written, and/or verbal) to whomever is responsible for billing and/or payment of services.

Confidentiality: I understand that Medical Acne & Skin Care, Inc. will not release any medical information without my permission with the exception of information that may be exchanged for medical billing and between those programs specified in a signed qualified services organization or business associate agreement between the agencies or information needed in a medical/health emergency. I understand that there are some limitations, as identified by state and federal law.

Insurance, Medicare, and/or Medicaid Title XIX Authorization: I authorize payment of insurance benefits directly to Medical Acne & Skin Care, Inc. I understand that I am personally responsible for charges not covered by the payor, and understand that I retain responsibility for all payments. If Medicare or Medicaid is a source of payment for treatment services, I understand that I have specific rights and responsibilities under the Social Security Administration and Medicaid Rules.

I have read the preceding information; understand and agree with it and the conditions of billing services as stated.

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Signature of Patient or Responsible Party **Date**