

## 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	d Cancer Associates (SCA) all
Name of Insurance Company(ies	)	
insurance benefits, if any, otherwise payable to me, for services rendered. I hereby authorize SCA to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am responsible for my health insurance deductibles and coinsurance.		
Beneficiary/Patient Signature	Relationship	Date
correct. I authorize any holder of medica intermediary carriers, any information nee	mation and payment request. in applying for payment under Title XV I or other information about me to releated for this or a related Medicare or Mf. I assign the benefits payable for phy	VIII and or Title XIX of the Social Security Act in the Social Security Administration or its
Patient Signature	Print Patient Name	Date
MEDIGAP NOTE: IF YOU SIGN F Beneficiary Signature Authorization. I request that payment of authorized Medi physician(s) of SCA. I authorize any holo	der of medical information about me to	SCA for services furnished to me by the
needed to determine these benefits or the b	penefits payable for related services.	release to my meangup earrier any minormation
	penefits payable for related services.  Print Beneficiary/	
Beneficiary/Patient Signature		
Beneficiary/Patient Signature  HIC (Medicare) Number  Name of Medigap Insurance Company	Print Beneficiary/	
Beneficiary/Patient Signature  HIC (Medicare) Number  Name of Medigap Insurance Company  PRIVACY NOTICE ACKNOWLE	Print Beneficiary/  Medigap Number  Date  DGEMENT	

Parent or Authorized representative (if applicable)