Bellevue Laser Cosmetic Center

Signature Sheet

I _____, have received a copy of the Bellevue Laser & Cosmetic Center Patient Office Policy and Notice of Health Information Privacy Practices. **I have read, understand, and agree to comply with these policies.**

_____ _____

Patient Signature **Date**

I give permission for you to see and treat _____(please print son/daughter's name), my minor son/daughter in your office.

_____ _____

*Signature of **parent/guardian (if patient is under 18**)* ***Date***

ASSIGNMENTS OF BENEFITS-MEDICARE (if applicable)

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid or its intermediaries or carrier any information needed for this or a related Medicare claim, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Signature as it appears on Medicare Card **Date**

ASSIGNMENTS OF BENEFITS-MEDIGAP (if applicable)

If you have a supplemental policy and it is a MEDIGAP policy to which you're Medicare carrier automatically "crosses over", we are required to keep a separate signature on file.
I request/authorize MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature as it appears on MEDIGAP Card **Date**

Benefits to Physicians: I hereby authorize payment of medical and/or hospital benefits directly to the physician by my insurance company or companies. I also understand that I am responsible for any portion of my bill not covered by my insurance company or companies.

Release of Information: I hereby authorize Bellevue Laser & Cosmetic Center to release or disclose appropriate medical records to any insurance company of third-party payer, liable **to the patient, for payment of claims.** I also authorize Bellevue Laser & Cosmetic Center. to release or disclose any medical records to the patient's primary care physician, consulting physician (s), and other health care providers who have a legitimate need for such information in the care and treatment of the patient. I understand that anyone else needing the patient's records, must have a signed "Records **Release"** by the patient. (A form other than this one)

_____ _____

Patient Signature **Date**