Summerlin Dermatology

911 N. Buffalo Drive # 113
Las Vegas, NV 89128
702-243-4501
www.summerlinderm.com

Private/Commercial or Medicare Insurance

Patient's Name: ___________________________ Date of Birth: _______________

Medicare No: _____________________________ Patient I.D. No._____________

I request that my payment of authorized Medicare benefits and, if applicable, Private or Commercial benefits, be made either to me or on my behalf to:

Summerlin Dermatology
Reuel Aspacio MD

for any services furnished to me by the provider.
To the extent permitted by the law, I authorize any holder of medical or other information about me to release to the healthcare financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the Physician or supplier agrees to accept the charges determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of medical carrier.

____ ____ __________________
Signature of Patient, Parent/Guardian or Personal Representative Date

____ ___________________
Please print name of Patient, Parent/ Guardian or Personal Representative Relationship to Patient