



MOORESVILLE DERMATOLOGY CENTER

SIGNATURE AUTHORIZATION FOR PAYMENT

I request that payment of authorized Medicare and or any other insurance benefits be made directly to Piedmont Healthcare, PA. for services furnished to me. I authorize any holder of medical information about me needed to determine these benefits or the benefits payable for related services, be released to Mooresville Dermatology Center and their agents. I am aware that cosmetic procedures will not be billed to my insurance company and I am responsible for payment at the time of service. I understand that if my financial account needs collection, all collection fees will be added to the original balance.

SIGNATURE OF PATIENT/RESP. PARTY: _____ DATE: _____

RECORDS RELEASE AUTHORIZATION

I hereby authorize and request the providers of Mooresville Dermatology Center to release the complete medical record in her possession concerning my illness and/or treatment to my primary care physician, referring physician, and my insurance company.

SIGNATURE OF PATIENT/RESP. PARTY _____ DATE _____

WAIVER OF REFERRAL (HMO POLICIES ONLY)

I understand that I am responsible for obtaining referrals from my primary care physician for each and every visit Mooresville Dermatology Center. I understand that If I do not have my referral for my visit or I wish to waive the use of my referral under my HMO program, I am responsible for my balance at the time of service.

SIGNATURE OF PATIENT/RESP. PARTY _____ DATE _____

THANK YOU FOR CHOOSING MOORESVILLE DERMATOLOGY CENTER!