



Consent Insurance Authorization and Medicare Secondary Payer Questionnaire

Insurance Authorization

- **AUTHORIZATION FOR MEDICAL TREATMENT:** I authorize Sutton Dermatology + Aesthetics to provide necessary care upon myself.
- **PARTICIPATING INSURANCE COMPANIES:** I authorize the release of any medical information necessary to process my claims. I also authorize payment of benefits to Sutton Dermatology + Aesthetics. I assume responsibility for any balance not paid by my insurance company
- **PRIVATE PAY AND NON-PARTICIPATING INSURANCE COMPANIES:** I authorize the release of any medical information necessary to process my claim. I assume responsibility for payment of this account. I understand that payment is expected at the time of the visit. I understand that Sutton Dermatology + Aesthetics does not participate with my insurance company.
- **MEDICARE PATIENTS ONLY:** I authorize the release of any medical information necessary to process my claims. I request payment of government benefits either to myself or to the party who accepts assignment. I also authorize payment of all other medical benefits filed by Sutton Dermatology + Aesthetics. I assume responsibility for any balance not paid by my insurance company.

Consent Acknowledgement: I have read and understand the information contained within this consent form. My signature below verifies this. Further, my signature below indicates my consent to the treatment described and my agreement to comply with the requirements placed on me by this consent form.

Signature

Date