Welcome to Carolina Skin Surgery Center

2615 E. 7th St. Charlotte, NC 28204 ~ Phone: 704-295-0000 ~ Fax: 704-295-0005 ~ Marc Carruth, M.D.

Authorization to Release Medical Benefits

- I authorize the release of all medical information necessary to process insurance claim(s) and I hereby assign and authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance, and other health plans to Carolina Skin Surgery Center.

- Please remember that medical insurance is considered a method of deferred payment and is not a substitution for payment. It is your responsibility to pay any deductible amount, co-pay, co-insurance or any other balance deemed patient responsibility by the insurance company. It is your responsibility to pay the balance in full if the insurance information you provide proves false or otherwise ineffective. It is your responsibility to follow all guidelines of your insurance company, including obtaining authorizations and referrals. You must inform our office prior to receiving service if your insurance coverage is through an HMO. Information regarding any change in your insurance coverage must be provided prior to receiving service.

- As a courtesy, our office will file with your primary and secondary insurance company after receiving a service in our office. For non-Medicare patients, you will be asked to pay at the time of service for all unmet deductibles, co pays, estimated coinsurance and non-covered services. If there is any remaining balance after your insurance has paid their portion of the charges, you will receive a statement from Carolina Skin Surgery Center. You will also receive a statement if the insurance has denied payment of the claim. Patients with Medicare as their primary carrier will receive a statement for any remaining balance after Medicare and their secondary insurance, if applicable, has paid.

- If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

- To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record to the patient's insurance company.

This Assignment will remain in effect until revoked by me in writing. A signed copy of this Assignment is to be considered as valid as an original.

Patient’s Name: ______________________________ Patient’s Signature:__________________________________

Our Medicare Compliance Pledge:

Our office is fully committed to compliance with all Medicare laws, rules, and regulations. If you ever have any questions or concerns about your services or charges, we encourage you to call and ask for our compliance officer.

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