Boise Dermatology
Naomi Brooks, MD
3109 S. Meridian Road
Meridian, ID 83642-7088
(208) 888-0660

Medicare Signature on File, Assignment of Benefits, and Financial Agreement

A. Medicare: I request that payment of authorized Medicare benefits be made on my behalf to **BOISE DERMATOLOGY** for any service furnished me by the listed provider/supplier.

I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services Administration (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health 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, Boise Dermatology agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Patient Signature Date

_____ _____
Name of Authorized Party Date

_____ _____
Signature of Authorized Party Date

B. Medigap: I understand that if I have a Medigap policy or other health insurance my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Boise Dermatology.

_____ _____
Patient Signature Date

_____ _____
Name of Authorized Party Date

_____ _____
Signature of Authorized Party Date

C. Advance Directive: Please indicate if the patient has executed any of the following advance directives:

[ ] **No**, [ ] **Living Will**, [ ] **Durable Power of Attorney**, [ ] **POST**