AFFILIATED DERMTOLOGISTS, INC.

Jill S. Mines, M.D., Edward A. Searle, M.D.
3901 Las Posas, Rd Ste. 108
Camarillo, CA 93010
805-484-3331

AUTHORIZATION TO PAY MEDICAL BENEFITS TO PHYSICIAN
Patient Demographic Information

I hereby request payment of Medicare and / or commercial insurance medical benefits to be paid directly to Affiliated Dermatologists, Inc, and / or Jill S. Mines, M.D., Edward A. Searle, M.D. I authorize the release to Medicare and / or my commercial insurance carrier any medical information necessary to process claims for medical services. I understand that payment of my account is ultimately my responsibility. I understand that if my insurance company does not respond to a properly sent claim with in 90 days, it is my obligation to pay the physician for the services. I understand that I will be financially responsible for non-covered services.

I declare that the information listed on my Patient Registration form is **Correct and Current**. I understand that it is **my responsibility** to inform the office of any changes in my address, phone number, insurance information, and emergency contact information

I am aware that I may be required to fill out a new Patient Registration Form if requested.

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Signature of Patient or Authorized Representative Date Employee Initials / Date

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Signature of Patient or Authorized Representative Date Employee Initials / Date

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Signature of Patient or Authorized Representative Date Employee Initials / Date

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Patient Name **DOB** **Acct #**