**PLEASE BE ADVISED THAT WE ARE STRICTLY OUT OF NET WORK WITH ALL INSURANCE PLANS INCLUDING MEDICARE. AS A COURTESY TO YOU, WE WILL SUBMIT TO YOUR INSURANCE CARRIER. IF YOU HAVE ANY QUESTIONS REGARDING YOUR PLAN COVERAGE PLEASE CALL YOUR INSURANCE CARRIER. LEARN WHAT YOUR DEDUCTIBLE IS, WHAT MAY OR MAY NOT BE COVERED, ETC**

****LESION REMOVAL FOR COSMETIC OR MEDICAL REASONS****

**We send all lesions, cysts and moles to a lab for analysis. Please provide your insurance information so that we may send it to the lab with the specimen.**

## **INSURANCE INFORMATION for Lab/Medical Procedure (not cosmetic) **

Insurance Company_______________________________________________

Insurance Address: _______________________________________________

City, State & Zip _________________________________________________

ID#________________________Group #____________________

Policy Holder Name: ____________________________________Date Of Birth__________________

Policy Holder Address: __________________________________Social Security #_______________

Policy Holder's Employer: ______________________________________________________________

Patient Relationship to Policy Holder: (circle one) SELF SPOUSE CHILD OTHER

## **ASSIGNMENT OF BENEFITS AND RELEASE INFORMATION**

I, the undersigned, hereby authorize my insurance carrier to make payment of medical/surgical benefits directly to Dr. Jill Hazen. I authorize the release of any medical information and or photographs to assist in collecting from my insurance carrier.

Signature of Patient and/or Legal Guardian______________________________Date:___________

I, the undersigned, realize that all medical and surgical charges incurred by me or my dependents are my financial responsibility.

Signature of Patient and/or Legal Guardian: _____________________________Date:___________

**PLEASE CIRCLE TYPE OF CLAIM: WORKER'S COMP AUTO ACCIDENT**

Date of Injury: ___________________________________Claim #_____________________________

If W/C, Employer-Contact Person: ___________________Phone #____________________________

Insurance Carrier: ________________________________ Phone#_____________________________