RESPONSIBLE PARTY INFORMATION ***(person responsible for the patient's insurance/billing if different than patient (ex: parent, guardian, or power of attorney).***

Responsible Party: _____

Relationship to Patient: _____

Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION ***(all patients to complete this section)*****:**

***Primary Insurance:** _____ **Policy Holder's SSN: __ __ __ - __ __ - __ __ __ __**

Policy Holder's Name: _____ Date of Birth: ____/____/___

Relationship to Patient:_____

***Secondary Insurance:** _____ **Policy Holder's SSN: __ __ __ - __ __ - __ __ __ __**

Policy Holder's Name: _____ Date of Birth: ____/____/___

Relationship to Patient:_____

I request that payment of authorized benefits be made to Messenger Dermatology for any services furnished by my provider. I authorize this office to release to my insurance carrier any information needed to determine benefits for related services. I have read and understand the office policies.

*Signature of Patient/Parent/Guardian:_____ Date: _____

*Items required per HIPAA regulations. We cannot bill insurance carrier if not completed.