M.A. STAWISKI, M.D.
DERMATOLOGY

YOU PRIVACY

I have been informed of the Notice of Privacy Practices for M.A. Stawiski, M.D., Dermatology

_____ _____

Signature Date

FINANCIAL POLICY

Patients who are covered by a private, commercial plans in which our physicians do not participate are required to pay 100% of the bill at the time of service. If covered by a plan with whom we have a contract, applicable co-payments and deductibles will be collected at the time of service, if determinable. You are due within 20 days of receiving a statement. Your signature indicates your willingness to comply with this policy.

_____ _____

Signature Date

AUTHORIZATION FOR PAYMENT

I authorize the release of information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I authorize payment of medical benefits directly to the physician.

_____ _____

Signature Date

SPECIAL AUTHORIZATION FOR MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made on my behalf to M.A. Stawiski, M.D., Dermatology for any services furnished me by their providers. I authorize the release of information to the Centers for Medicare and Medicaid Services and its agents in order to determine benefits and payment of the claim. If "other health insurance" is indicated I authorize releasing of the information to the insurer or agency shown. I permit a copy of this authorization to be used in place of the original. I understand I am responsible for co-insurance and deductible amounts as directed by my Medicare carrier. (M.A. Stawiski, M.D., Dermatology is a participation provider.)

_____ _____

Signature Date

Would you like to be notified by email about cosmetic services or product special we offer?

_____

Email address

How did you hear about us? ☐ Doctor ☐ Friend ☐ Family Member ☐ Internet
☐ Yellow Pages ☐ Other _____