My Signature below authorizes the evaluation and treatment at the office of Perri Skin Care/Surgical Specialties; including taking appropriate history, examinations, and other tests or procedures necessary for medical treatment.

MEDICARE PATIENTS ONLY

My signature below authorizes the office of Perri Skin Care/Surgical Specialties or its agent to release medical information about me to Medicare, Medicaid, and/or Medigap (secondary insurance). Any information required to determine benefits of the benefits payable for related services be released to the healthcare financing administration and/or its agents. I request that all payments of medical insurance benefits be made directly to the office of Perri Skin Care/Surgical Specialties.

FOR ALL PATIENTS OTHER THAN MEDICARE

My signature below authorizes the release of any medical or other information necessary to process any claim. I request that all payments of medical insurance benefits be made directly to the office of Perri Skin Care/Surgical Specialties. I understand that I am financially responsible for any amount not covered by my health insurance. I understand that if my insurance requires a referral from my primary care physician, it is my responsibility to obtain one for each and every visit. If one is not obtained I understand that I will be responsible for services rendered without a referral.

MEDICAL RECORDS RELEASE

My signature below authorizes the release of my medical information to my insurance company and/or consulting physician by mail, fax, or secure internet.

HIPPA POLICY

My signature below verifies that I have received a copy of Perri Skin Care/Surgical Specialties HIPPA Privacy Act.

BILLING POLICY

My signature below verifies that I understand it is my responsibility to pay my balance owed. I also understand that failure to do so in a timely manner could incur an interest fee of up to one third percent of my balance.

Patient or Responsible Party's Signature	Printed Name and Relation	Date