HYDE PARK DERMATOLOGY
1525 E. 55TH STREET
SUITE 307
CHICAGO, IL 60615

MEDICARE INSURANCE: PATIENT SECONDARY INSURANCE PAYMENT AGREEMENT

ASSIGNMENT AND RELEASE

I certify that I, and /or my dependent(s), have coverage with Medicare, and a secondary insurance carrier that is accepted by Hyde Park Dermatology (**BLUE CROSS/ BLUE SHIELD PPO, PRIVATED HEALTH CARE SYSTEMS, UNITED HEALTH CARE PPO, HUMANA PPO**), and assign directly to Dr. Honore all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all submissions.

Dr. Honore may use my health care information and may disclose such information to Medicare and the above mentioned accepted secondary insurance companies, and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment is completed.

Signature of Patient, Parent, or Personal Representative Date

Please print name of Patient, Parent or personal representative Relationship to Patient