LIFETIME AUTHORIZATION

FOR INSURANCE REIMBURSEMENT:

I authorize the release of information contained in my medical records that is necessary for my treatment, required for insurance payments or is related to other associated health care operations.

I, the undersigned, understand that Scott B. Karlene, M.D., P.C. has agreed to accept Medicare, BCBS of Michigan, Health Plus of Michigan and/or health insurance that we participate with for payment of my bills. By my signature below, I acknowledge and understand that I am fully responsible for any yearly deductible, co-insurance and/or non-covered services which are to be paid by me to: Scott B. Karlene, M.D., P.C. I understand that I will be billed for the remaining unpaid balance and I understand that I am financially responsible for any charges not covered by this authorization. I understand, if my insurance is an HMO, a referral is required at the time of each visit. If no referral is present at the time of service, I understand that I will be held responsible for any and all charges accrued.

METHOD OF PAYMENT

Payment is expected from you at the time of service for your portion of the charges. We accept VISA, MASTERCARD and DISCOVER for your convenience.

FOR THE RELEASE OF MEDICAL INFORMATION

I give permission to discuss my medical information and treatment with the following individual(s):

_____
Name

_____
Name

_____
Name

Signature _____ Date _____

THANK YOU FOR SELECTING DR. SCOTT KARLENE FOR YOUR DERMATOLOGICAL CARE. The information requested on this form must be completed in it's entirety and will remain confidential. If you have any questions or require assistance, please do not hesitate to ask. We are here to serve you!