

BENEFICIARY AGREEMENT: CHART:# _____

I DO NOT BELIEVE THAT MY SKIN CONDITION IS WORK RELATED.

MEDICARE PATIENTS:

I authorize any holder of medical or other information about me to release to the Social Security and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claims.

I permit a copy of this authorization to be used in place of the original. I request payment of medical insurance benefits either to myself or to the party accepting assignment. I have been notified by my physician that he believes that, in my case, Medicare is likely to pay for today's service but if Medicare denies payment, I agree to be personally and fully responsible for payment.

NON-MEDICARE PATIENTS:

I authorize the release of any medical information necessary to process an insurance claim. If Michael J. Freeman, M.D. and/or David Kosiorek P.A-C. Elects to accept an assignment, I authorize payment of medical benefits to Michael J. Freeman, M.D., P.A. However, I am personally and fully responsible for payment.

I hereby authorize Michael J. Freeman, M.D. and/or David Kosiorek P.A-C. to release to any physician, hospital, medical care facility, or pharmacy, any information acquired in the course of my examination or treatment. I hereby authorize any physician, hospital, medical care facility, or pharmacy, to provide all medical history to Dr. Freeman. I authorize the release of any medical information necessary to process an insurance claim. I also request payment of insurance benefits either to myself or to Michael J. Freeman, M.D., P.A. Prescriptions are normally processed by electronic means.

I understand Dr. Freeman *may not* file secondary insurance. Billing secondary insurance is a *courtesy* to Dr. Freeman's Medicare patients. However, if my secondary insurance *DOES NOT* pay within *60 days* of the filing date, I (the patient) *am responsible* and will be billed for the balance. If my insurance cards are not available for copying at my appointment time and/or within 48 hours, I (the patient) am responsible for my charges and will be billed directly. I understand that Dr. Freeman's office uses an *automated system* to verify patient appointments and that in the event an answering machine picks up, the system will leave a message.

I understand that I am *personally responsible for all services rendered*. I understand that *if a biopsy* is warranted and consent is given, the *biopsied specimen* will be sent to a specialized Physician (Pathologist) of *Dr. Freeman's choice* for microscopic evaluation. The lab *may or may not* participate with *my insurance* and I understand that I will be *billed separately* for their services. I understand that Dr. Freeman *DOES NOT* participate in the *Medicaid program* and I (the patient) *will be responsible for any charges incurred*.

If it becomes necessary to engage a *collection agency* and/or *an attorney* to collect any amount that may be due, then I agree to pay any charges associated therewith, including *collection charges and/or a reasonable amount of attorneys' fees and court costs*, regardless of whether litigation is commenced. I also agree to pay interest at the rate of 18% per annum if my account becomes delinquent in excess of 10 days. Disputes (monetary or medical) will be settled by arbitration (one selected by Dr. Freeman, one by myself, and the final arbitrator agreed upon by the first two.) This is a waiver to a jury trial.

Please Note: This office is regulated pursuant to the rules of the Florida Board of Medicine as set forth in Chapter 64B8, Florida Administration Code. You (the patient) are entitled to know that this office follows the intent of the Patients' Bill of Rights with its guidelines for patient's privacy. Please feel free to ask the receptionist if you desire a copy of this document. You will also find a *copy* of the Patients' Bill of Rights located in each patient exam room. You (the patient) have the right to *refuse to sign this notice*, but by the same right, Dr. Freeman and/or David Kosiorek P.A-C have the right to *refuse treatment* to you (the patient).

My signature acknowledges that I have read (and/or had read to me) and understand this form. One purpose of my signature on this form is to comply with regulations requiring my signature to be "on file" for filed claim forms.

_____	_____
PLEASE PRINT PATIENT'S NAME	PATIENT'S SIGNATURE
_____	_____
PARENT OR GUARDIAN'S NAME (PLEASE PRINT)	PARENT OR GUARDIAN'S SIGNATURE

TODAY'S DATE: _____

REASON PATIENT IS UNABLE TO SIGN: _____