Bella Dermatology & Medical Spa

Terry L. Sharpe, M.D.

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AUTHORIZATION TO PAY/ FOR MEDICARE, LIFETIME AUTHORIZATION

I authorize any holder of medical or other information about me to release to my insurance company, and, for Medicare, to the Social Security Administration and Health Care Financing Administration or its intermediaries or carries or billing agents, any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original. I further authorize payment of medical and / or surgical insurance benefits, otherwise payable to me, to the party who accepts assignment. I understand that I am financially responsible for those charges not paid by my insurance.

I, the undersigned, recognize that it may be necessary for my child (named above) to receive medical treatment at a time when I am unable to be present. Therefore, I authorize Terry L. Sharpe, M.D. and her staff to perform such routine medical treatment as may be necessary for the care of my child.

Signed_____Date_____

(Parent/Guardian)