Deerfield Dermatology Associates, Ltd.

Diplomates of American Board of Dermatology
Marcia E. Johnson, M.D.
Jonathan A. Dalton, M.D.
Divya Singh-Behl, M.D.
Madhuri V. Konanahalli, M.D.

MEDICARE PATIENT QUESTIONNAIRE

Patient Name _____ **Date of Birth**_____

Answer questions below by placing a check in the appropriate column:

YES	NO	
❑	❑	Have you recently joined a Medicare Advantage Plan? If yes, identify: _____
❑	❑	Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?
❑	❑	Are you covered by a commercial HMO/PPO which makes Medicare secondary?
❑	❑	Is this illness covered by the VA (Veteran's Administration)?
❑	❑	Is this illness covered by the Federal Black Lung or End Stage Renal Disease Program?
❑	❑	Is this illness due to an automobile accident?
❑	❑	Is this illness due to an injury at work?
❑	❑	Are you receiving Medicaid?

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MEDICARE PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize Deerfield Dermatology Associates, Ltd. to release medical or other information to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ ____/____/____
Signature as it appears on Medicare card *Date*

If you have a supplemental policy and it is a supplemental policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:
I request authorized supplemental benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to _____ (please indicate supplemental carrier's name) any information needed to determine these benefits or the benefits payable for related services.

_____ ____/____/____
Signature as it appears on supplemental card *Date*

Do you give our office permission to discuss your medical information with family members? ❑ YES ❑ NO
If yes, please provide their name and phone number.

Name: _____ Relationship: _____

Phone # (day): (____)_____ Evening #: (____)_____

May we leave personal medical information on your answering machine at home? ❑ YES ❑ NO

May we e-mail personal medical information to you? ❑ YES ❑ NO

E-mail address: _____

Patient Signature: _____ Date: ____/____/____