

Assignment of Benefits

I request that payment of authorized benefits be made on my behalf to M D Aesthetics and Dermatology LLC for any services furnished to me by Dr. Gabriel J. Martinez-Diaz, employees and associates. I assign my right to receive these payments to M D Aesthetics and Dermatology LLC. I authorize M D Aesthetics and Dermatology LLC to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my insurance carrier and its agents will not direct payment to M D Aesthetics and Dermatology, LLC I agree to forward to M D Aesthetics and Dermatology, LLC all health insurance payments, which I receive for the services rendered by Dr. Gabriel J. Martinez-Diaz, employees and associates. I authorize M D Aesthetics and Dermatology, LLC or any holder of medical information about me to release to the insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services. I acknowledge that this authorization will be valid for all subsequent visits unless cancelled in writing by me or an authorized agent.

I designate M D Aesthetics and Dermatology, LLC as an authorized representative to act on my behalf in regard to claims submitted to any employee health plan or other source of Third-Party Coverage for Services rendered by M D Aesthetics and Dermatology, LLC. This designation includes, but is not limited to, initial determinations, requests for documents, requests for additional information and appeals. I further authorize M D Aesthetics and Dermatology, LLC to execute any documents necessary to process claims for reimbursement of charges for Services received by Patient.

Signature of patient/authorized agent

Date