



Assignment of Benefits

I request that payment of authorized benefits be made on my behalf to Fresh Dermatology, P.A. for any services furnished the patient listed above by Dr. Thrash and her staff and associates, and I assign my right to receive these payments to Fresh Dermatology, P.A.

I authorize Fresh Dermatology, P.A. 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 Health Insurance Plan will not direct payment to Fresh Dermatology, P.A., I agree to forward to Fresh Dermatology, P.A. all health insurance payments, which I receive for the services rendered by Dr. Thrash and her staff and associates.

I authorize Fresh Dermatology, P.A. or any holder of medical information about me or the patient listed above to release to my Health Insurance Plan such information needed to determine these benefits or the benefits payable for related services.

Signature Patient/Guardian: _____

Printed Name: _____

Date: _____