CALIFORNIA SKIN INSTITUTE

Patient Assignment of Benefits

Select the appropriate office location

San Jose/Los Gatos
2420 Samaritan Drive
San Jose, CA 95124

Mountain View
525 South Drive,Suite 115
Mountain View, CA 95040

San Jose / O'Connor
2100 Forest Avenue, Suite 103
San Jose, CA 95128

Saratoga
18988 Cox Avenue, Suite B
Saratoga, CA 95070

Los Altos
129 Fremont Avenue
Los Altos, CA 94022

Monterey/Ryan Ranch
9781 Blue Larkspur Lane, St Suite 100
Monterey, CA 93940

San Mateo
136 North San Mateo Drive,2nd Floor
San Mateo, CA 94401

San Francisco Lauriel Heights
3905 Sacramento Street, Suite 201
San Francisco, CA 94118

San Francisco Pacific Heights
2100 Webster Street, Suite 318
San Francisco, CA 94115

Salinas
559 Abbott Street,Suite A
Salinas, CA 93901

Santa Cruz County
204 Green Valley Road
Freedom, CA 95019

Monterey
977B Pacific st
Monterey, CA 93940

South San Jose
393 Blossom Hill Road,Suite 290
San Jose, CA 95123

Daly City
1800 Sullivan Avenue,Suite 403
Daly City, CA 94015

Castro Valley
20055 Lake Chabot Rd Ste 150
Castro Valley, CA 94546

All Patients, Please Read and Sign:

This form is required to allow us to bill and accept direct payment from your insurance company or other payer.

California Skin Institute will bill all primary and secondary insurances, but I am ultimately responsible for payment for the services and any supplies/equipment I receive.

I hereby assign to California Skin Institute AMC any insurance or other third party benefits available for healthcare services provided to me. I understand that the California Skin Institute (CSI) has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to the California Skin Institute, I agree to forward to the California Skin Institute all health insurance and other third party payments that I receive for services rendered to me immediately upon receipt.

I understand that my signature requests that payment be made directly to the California Skin Institute. I authorize release of medical information necessary to pay the claim.

A photocopy of this assignment is to be considered as the original.

I have read and agree with the above Patient Assignment of Benefits. I understand the terms and conditions outlined herein as confirmed by my signature below

Patient or Responsible Party's Signature: _____ Date Signed _____

Patient's Printed Name: _____ Patient's Age * _____

* NOTICE: If patient is a minor (under 18 years of age) the parent of responsible party must complete and sign the Consent for Treating of Minor Form.