

Insurance Signature on File 2026

I request that payment of authorized benefits be made on my behalf to M D Aesthetics and Dermatology PLLC 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 PLLC.

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, PLLC 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, PLLC 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, PLLC 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, PLLC. 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, PLLC to execute any documents necessary to process claims for reimbursement of charges for Services received by Patient.

By signing below, you acknowledge that you have received and understand this notice,

Patient or Legal Guardian
DOB: