Adam S. Plotkin, M.D., P.A.
Ronnit H. Stein, M.D.
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Kathleen B. Herne, M.D.

Palm Beach
DERMATOLOGY GROUP
healthy beautiful skin for a lifetime

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561-499-0660
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Insurance Affidavit

Name: _____ Date: _____

COMPLETE ONE

1. I have paid my Medicare Part B Deductible to:

_____on: _____.

2. My Insurance Company: _____ has agreed to pay my annual Medicare Deductible.

3. Other:

In the event that Palm Beach Dermatology Group has any portion of the fee deducted as a result of my insurance not paying, I agree to pay that amount.

Patient Signature: _____