STX SOUTHTEXAS DERM DERMATOLOGY

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SELF-PAY ACKNOWLEDGEMENT

I, _____, acknowledge that my insurance may not cover today's visit. I agree to be personally responsible for payment of all charges for services provided on _____.

If my insurance company later pays for this visit, I agree to notify South Texas Dermatology. I understand that any overpayment will be refunded after insurance processing, minus any applicable copayments, deductibles, cost sharing, or non-covered services.

I am electing to pay privately for the following reasons:

☐ I do not have insurance and will be paying privately.

☐ I did not bring a valid insurance card.

☐ I did not obtain a required referral from my Primary Care Physician (PCP) or this office has not received an authorization for my visit.

☐ My referral was denied by my referring physician/PCP.

☐ No participating dermatologist is available under my insurance PPO/HMO/PHO plan.

☐ I am choosing not to use my insurance for this visit.

Private Pay (Self Pay):

Payment in full is required at the time of service unless prior arrangements have been made. If the balance is not paid in full at the time of the visit, charges may revert to the full billed amount.

Patient Name (Printed) _____

Signature _____

Date _____