intentional
dermatology and health
INTEGRATING AESTHETICS, WELLNESS AND ALL THINGS SKIN

Patient Financial Responsibility Form/ Self-Pay Waiver

Thank you for choosing Intentional Dermatology and Health for your medical needs. We are committed to providing you the highest quality healthcare. We ask that you read, make the appropriate selection, and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care. **PLEASE CHECK ONE BELOW:**

☐ Check here if you agree to the **self-pay rate for services rendered, at time of service.**

☐ Check here if you elect to use available medical insurance for visit coverage. Self-pay rates **will not** apply after date of service.

- We will bill your insurance for you; however, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
- Co-pays are due at the time of service.
- Co-insurance, deductibles, and non-covered items are due after your insurance(s) have responded.
- Patients may incur, and are responsible for payment of additional charges, if applicable.

By my signature below, I hereby authorize assignment of financial benefits directly to Intentional Dermatology and Health for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient Name: _____ Date:_____

Patient/Legal Guardian Signature: _____