

# Skin Wellness Center of Alabama

## Statement of Patient Financial Responsibility

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Skin Wellness Center of Alabama appreciates the confidence you have shown in choosing us to provide for your health care needs. The services you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/ co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full. I agree to pay any costs incurred by the Skin Wellness Center of Alabama in collecting any amounts due including, without limitation, collection agency fees and attorney's fees.

I have read the above policy regarding my financial responsibility to Skin Wellness Center of Alabama, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Skin Wellness Center of Alabama, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

Guarantor Signature \_\_\_\_\_ Date: \_\_\_\_\_

### Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay EACH VISIT. Thank you for your cooperation in the matter.

Patient/Guarantor Signature \_\_\_\_\_ Date: \_\_\_\_\_

### Self-Pay

I do not have health insurance and will be responsible for services rendered here at Skin Wellness Center of Alabama. I agree to pay the practice the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_