.the derm studio.

Financial Responsibility Agreement

I have chosen to receive services from Dr. Kristen Forman/ Dr. Samreen Choudhry/ Holly Beardsley PA-C/ Amber Young PA-C.

If I am using insurance, I understand that my benefits may not be verified at this time.
It is my responsibility to know my benefits. Out of courtesy, The Derm Studio staff will attempt to verify benefits.

I understand I am responsible for all deductibles, co-payments and non-covered expenses. If we are not an in-network provider, then I understand out-of-network expenses are my responsibility. I am also aware that any outside services (i.e. lab, biopsies sent to pathology) ordered by the physician are also my financial responsibility depending on my individual insurance carrier.

If I am a cash-paying patient, I am responsible for all charges incurred by The Derm Studio as well as additional charges incurred with outside services (i.e. lab, biopsies sent to pathology) ordered by the provider. I will receive a separate bill from the lab or pathologist for these charges.

_____ _____

Patient Name Date

_____

Patient Signature