

**WAIVER OF LIABILITY RELEASE FORM**

I, (Patient's Name) \_\_\_\_\_ on (Date) \_\_\_\_\_ understand that the following will apply and be enforced as long as I am a patient at Sierra Skin Institute:

Your insurance company may determine that the procedures or services provided for you by this office are not deemed medically necessary or are non-covered services. It is possible that your insurance may deny payment based on any of the following:

The procedure is considered a *cosmetic service*.

The procedure is a *non-covered service* under your health plan.

We are *not* a contracted provider with your insurance carrier.

You did *not* obtain a required *referral* from your insurance carrier.

If my insurance carrier denies payment for the services provided by this office for any of the reasons stated above, I agree to be personally and fully responsible for payment.



**FINANCIAL CONTRACT/AGREEMENT**

**I understand there is a \$50 charge for any appointment missed or cancelled with less than 24 hour notice.**

I understand that if I do not pay my account with Dermatology Associates DBA Sierra Skin Institute in full, my account may be assigned to a collection agency for collections of outstanding monies owed.

I also understand that if my account is assigned to a collection agency, the collection agency will charge a commission or fee that may be as much as 50% of the amount I owe to Dermatology Associates DBA Sierra Skin Institute. In addition to this fee/commission, Dermatology Associates DBA Sierra Skin Institutes may add a monthly service charge of \$10.00 per month for overdue accounts 45 days past the initial billing date.

I understand and agree that in the event legal action is commenced to enforce my obligations hereunder, that I will pay court costs and reasonable attorney's fees.

\_\_\_\_\_  
Patient's (or Guarantor's if patient is a minor) Signature Date

\_\_\_\_\_  
Witness's Signature Date