FOREFRONT DERMATOLOGY®
AND AFFILIATED PRACTICES

Request for Insured Patients Requesting Self-Pay Patient Status

Patient Name (PLEASE PRINT): _____ **Date of Birth:** _____

This acknowledges my request for my medical services to be coded as self-pay and not billed to my insurance carrier. At the time of service, the clinic will collect a **down payment** from me as indicated on the Patient Communication and Financial Policies Form. The clinician may require payment in full for procedural services prior to rendering such a service. You (or your legal guardian) can contact the Billing Department at 866-630-9882 for the exact amount required to pay the balance in full.

I have decided on my own accord that:

- I do not want a claim for today's office visit, procedure, or other services received from Forefront Dermatology, S.C., or one of its affiliated practices ("Forefront"), to be submitted to my insurance carrier, and

- I shall not submit any charges from today's visit to my insurance carrier.

I further direct Forefront not to submit a claim to my insurance carrier for these services.

Please note that electing self-pay status for this visit may affect your insurance company's coverage decision on subsequent related services, if applicable.

Signature: _____

Printed Name: _____

Minor's Name (if applicable): _____

Date: _____

Witness Signature: _____

Witness Printed Name: _____

Effective: 2/1/2024