

Affidavit of No Insurance

Patient Name (PLEASE PRINT): _____

DOB: _____

I, _____, being first duly sworn, do hereby state under oath and under penalty of perjury that the following facts are true:

1. I am over the age of 18 (or 19 in the state of AL) and I am a resident of the State of _____, and have personal knowledge of the facts herein.
2. I do hereby swear that I have no medical health insurance for payment of medical bills associated with my, or my child's (if applicable), treatment by Forefront Dermatology, S.C. and its affiliated practices ("Forefront"). I hereby state that neither I, nor my child (if applicable), was qualified to collect medical benefits under the policy of any other individual at the time of service, nor is any third party liable for the costs of such services.
3. I understand and acknowledge that payments made on the date of service are a down payment towards the final balance due, determined only upon finalization of clinic and pathology services rendered.

Signature: _____

Printed Name: _____

Minor's Name (if applicable): _____

Date: _____

Witness Signature: _____

Witness Printed Name: _____