BEND DERMATOLOGY
CLINIC
DERMASPA

Private Pay Agreement

I understand that _____ is accepting me as a private pay patient for the service date of _____, and I will be financially responsible for any services that I receive. I have elected to pay for all services and do not wish for my Provider to file a claim to my insurance carrier. I understand payments made will not now, nor in the future, be credited towards satisfying any deductible or out-of-pocket amount I may be subject to under my health insurance plan. I understand payment in full is due at the time of service or the agreement is void.

Signature_____

Print Name_____

Relationship to Patient_____

Date _____