FINANCIAL RELEASE FORM

- I hereby authorize direct payment of surgical/medical benefits to Distinctive Dermatology, LTD, for services rendered by the physician in person or under the physician's supervision.

- I understand that I am financially responsible for any balance not covered by my insurance. I, understand that I am financially responsible for the full amount of the office visit and or services if my insurance carrier requires a referral and one is not obtained.

- Please be informed that there is a **$50.00 NO SHOW** fee for Established visits **$100.00 NO SHOW** fee for Scheduled Surgeries and Cosmetics appointments.

- This fee has to be paid in full before you are seen again in our office. This fee may not be billed to your insurance.

- If we have to refer your account to a collection agency, you agree to pay all of the collections costs which are incurred.

Patient Name(Please Print):________________________________

Patient/Guardian Signature:________________________________

Date:____