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**FINANCIAL POLICY STATEMENT**

My insurance will be billed solely as a courtesy. I am responsible for the entire bill when services are provided. If my insurance carrier does not remit payment or notification to my provider within 60 days, the balance will be due from me. If my insurance company requests a refund of payments, I will be responsible for the amount of money refunded to my insurance company. In the event my insurance company establishes an internal usual and customary fee schedule, I will be responsible for the difference remaining.

**Self-pay services may be requested due on the date of service**.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

I understand that Fargo Center for Dermatology is not a provider for Worker’s Compensation and I may be held liable for the total amount of charges for services provided.

**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(parent/legal guardian if patient is under 18)**