Bloom Dermatology

Self-Pay Agreement

I have been informed and understand medical insurance will ***NOT*** pay for the services listed on this estimate because they are ***NOT*** medically necessary. I have requested that services be performed for personal and/or cosmetic reasons.

I Agree To Pay Any And All Charges Associated With:
1.) Performing Any And All Services Detailed On This Estimate
2.) Any And All Follow-Up Services, Routine Or Emergency, Related To Services Detailed On This Estimate

I understand that Bloom Dermatology will use HCPCS Level II diagnosis code V50.9 (elective surgery for purposes other than remedying health states) to classify these services, and will not file a claim to any insurance company. No payment made for these services will be applied to any insurance deductible.

Upon discovery that an administrative error resulted in an unintended filing of a claim to your insurance carrier and subsequent inappropriate payment to Bloom Dermatology, we will refund your insurance carrier. You remain responsible for all charges.

This estimate applies to conditions as of this date; if conditions change before the procedure, this estimate will become invalid and a new estimate will be provided. If during the course of a procedure it is found that a more extensive or complex procedure is required, the patient assumes the risk of any additional charges. **THIS ESTIMATE IS VALID FOR 90 DAYS.**

PROCEDURE	$ EACH	#	PRICE
1. _____	$_____	X_____	$_____
2. _____	$_____	X_____	$_____
3. _____	$_____	X_____	$_____

I ACCEPT AND AGREE TO PAY MY BILL IN FULL AT THE TIME OF SERVICE AND UNDERSTAND THAT THERE ARE NO PAYMENT PLANS.

Signature of Patient/Guardian/Beneficiary

Signature of Provider