

# CASTLE ROCK DERMATOLOGY, PC

*Amy Broomer, DO*

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## SELF PAY FORM

Date of Service: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Last**        -        **First**        -        **MI**

My signature below confirms that I am a self-pay patient.

I **DO NOT** have:

Medicare, Medicaid or any Commercial Insurance Plans of any kind, including Out of Network Insurances, EPO's or HMO's. I will not be submitting these charges to any insurance plan for re-imburement

I will personally be responsible for all charges connected with the services for the above date of service

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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