CASTLE ROCK DERMATOLOGY, PC

Amy Broomer, DO

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-imbursement

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

Signature:____Date:______________