BARRINGTON-PARK
DERMATOLOGICAL
ASSOCIATES, P.C.

Elizabeth P. Francis, M.D.
Kassie A. Haitz, M.D.
Pamela A. Leve, M.D.
Stephen L. Pelton, M.D.
Shannon B. Routhouska, M.D.

Financial Waiver

Date: _____

Name: _____ DOB: _____

Insurance: _____ Doctor: _____

I agree to pay for any balance due or pay in full for the cost of the health services described below

[ ] Barrington Park Dermatological Associates is a non-participating with my insurance company.

[ ] I did not first contact my Primary Care Physician to obtain the required referral for my visit to Barrington Park Dermatological Associates

[ ] Authorization to Barrington Park Dermatological Associates was denied by my Primary Care Physician

[ ] The health services provided are not a covered benefit under my insurance company

[ ] I do not have insurance and will be self-paying for today's appointment

[ ] Other

Your disclosure to me as described above, and my signing of this agreement were done prior to receiving the health services at Barrington Park Dermatological Associates.

Barrington Park Dermatological Associates _____ _____
Staff initials Patient signature

_____
Parent/guardian signature if patient is under 18

Description of health services:

_____

_____

_____

220 Linden Oaks, Suite 300 • Rochester, NY 14625 • Tel (585) 383-4420 • FAX (585) 383-4515