ADULT AND PEDIATRIC DERMATOLOGY

OF TULLAHOMA, PC

Date of office visit: _____

Name of patient: _____

I, the undersigned, understand that I am a self-pay patient with no insurance coverage.

As such, I am obligated to pay for my services at the time they are rendered. The method by which I will be paying for today's office visit is:

Cash _____

Check _____ #: _____

Credit Card:

Visa _____ Master Card _____ American Express _____ Discover _____ Other _____

Number on card: _____

Name on card: _____

Expiration date: _____

Patient, Parent or Legal Guardian Signature: _____

Date: _____