Central Carolina Skin & Dermatology Center

Notice of Cosmetic Service
(A Medically Unnecessary Service)

Date: _____

Patient Name: _____ Procedure: _____

Estimated Charge: _____

Reason for cosmetic procedure: _____

Your signature on the bottom of this form signifies that you understand that the service identified above is a cosmetic service and will not be filed with any insurance plan. Your decision to have this service rendered and your signature indicates an understanding that the procedure is performed strictly for cosmetic purposes, is not medically necessary, and therefore, will not be submitted to your insurance plan/managed care plan for payment.

You will be responsible for payment in full at the conclusion of the visit and fully accept the fact that the charges incurred are out-of-pocket expenses and you will not bill the expenses to your health care plan. _____ (Initial)

You will not receive a coded receipt for the service(s) you were rendered since these services will not be submitted to your insurance carrier. Your check or credit card slip is your receipt. If cash is paid a cash receipt will be provided. _____ (Initial)

This consultation and/or service is strictly for cosmetic purposes and in no way should be construed as replacing a dermatological skin exam by a Physician. If you wish to be seen by a Physician in the Central Carolina Skin & Dermatology Center office for the diagnosis and treatment of any skin problem and/or skin lesions, our staff will be glad to assist you in scheduling an appointment at one of their regularly scheduled appointment times. ____ (Initial)

Please sign below to show that the above information has been explained to you and that you understand the purpose of your cosmetic consultation today.

_____ _____

Patient/Guardian Signature Date

_____ _____

Patient/Guardian Signature Date