Washington Dermatology

No Show/Cancellation Fees

If you fail to notify us of appointment cancellation on or before your scheduled appointment, a $75 No Show fee will be billed to your account.

I have read and agree to the above statements.

_____ _____

Print Name Signature

_____

Date

Please Read Carefully

1. Patient will be responsible for all amounts not covered by insurance. We accept Visa, Mastercard, American Express and Discover. etc.
2. I acknowledge that I am fully responsible for all charges incurred for services rendered to me. Any payments received from an insurance company will be credited to my account and I will be liable for any unpaid balance. I understand that if I don't pay, I may be transferred to a collection agency.
3. I hereby authorize the release of all information relating to any claim for benefits on behalf of myself and/or my dependents. My signature on this document authorizes Yolanda C. Holmes, M.D., F.A.A.D. to submit claims for benefits arising from services rendered.

Consent For Treatment

I hereby consent to the rendering of care by Yolanda C. Holmes, M.D., F.A.A.D. which may include laboratory testing and other procedures, and other such medical treatment as Dr. Holmes considers necessary and advisable.

Signature _____ **Date** _____

Yolanda C. Holmes, M.D., F.A.A.D.
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