FOREFRONT DERMATOLOGY®
AND AFFILIATED PRACTICES

AFFIDAVIT OF NO INSURANCE

Patient Name: ________________________________ **MRN #** ______________________________________

I,_____________________________________, being first duly sworn do hereby state under oath and under penalty of perjury that the following facts are true:

1. I am over the age of 18 and I am a resident of the State of_______________________________________, and have personal knowledge of the facts herein.

2. I due hereby swear that I have no medical health insurance for payment of medical bills associated with my, or my child's (if applicable), treatment by Forefront Dermatology, S.C. I hereby state that neither I, nor my child (if applicable), was qualified to collect medical benefits under the policy of any other individual at the time of service, nor is any third party liable for the costs of such services.

3. I understand and acknowledge that payments made on the date of service are a down payment towards the final balance due, determined only upon finalization of clinic and pathology services rendered.

Signature:________________________________

Printed Name: ____________________________

Date: ___________________________________

Child's name (if applicable)

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WITNESS:

Signature: _______________________________

Printed Name: ____________________________

Updated 4/16/2021