

SOUTH COAST DERMATOLOGY

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INSURANCE WAIVER

«PNumber»

January 9, 2009

«PName»

«PL1CarrName»

By signing below I acknowledge that there is no proof of insurance for my visit today. I understand that I may be seen today and that it is my responsibility to contact *SOUTH COAST DERMATOLOGY* with a current copy of my insurance card. If my insurance information is not provided within the next **24 hours**, I will be solely responsible for the full amount of the services rendered to me today. Please fax a copy of your insurance card to our fax: **781-335-9709**.

SIGNATURE: _____

DATE: _____