ARLINGTON CENTER FOR DERMATOLOGY
"Comprehensive Family Skin Care"
• Medical • Surgical • Cosmetic

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PATIENT WAIVER
OF MEDICAL NECESSITY FORM

As a patient of Arlington Center for Dermatology, the initial office visit to evaluate your problem should be covered by your insurance company. You will only be responsible for the copay, coinsurance and/or deductible charges on your visit at the time of service as determined by your insurance company . For any procedure or treatment of these specific diagnoses, you will be responsible for the payment at the time of service, because these services may not be covered if they are considered not medically-necessary by your insurance company. We will file the insurance claim for you. Should the insurance company pay for these services, we will promptly refund you any portion not considered "patient liability".

The following conditions and treatment of these conditions MAY NOT be considered as medically necessary:

- Skin tags
- Seborrheic keratoses (raised crusty brown "moles)
- Keloids
- Dermatosis papulosa nigra (multiple small seborrheic keratoses of the face)
- Benign growths (such as "moles")
- Milia ("whiteheads")
- Sebaceous hyperplasia ("overactive" oil glands of the face)
- Cherry angiomas (red "moles")
- Telangiectasias of the face (small "broken" blood vessels of the face)
- Cysts
- Warts (non-cancerous lesions)
- Lentigo ("age spots" or "liver spots")

These services **WILL NOT** be covered by your insurance company because they are not considered medically-necessary. You are fully responsible for payment of these procedures/services at the time of service. No claim will be filed to your insurance company for these services. Should you file an insurance claim from this visit, we will not take any write-off or discount for services rendered.

- Chemical Peels
- Wrinkle treatment with Retin-A *andlor* glycolic acid
- Removal or treatment of benign asymptomatic growths (noted above)
- Sclerotherapy for spider veins
- Collagen, fat or silicon injections
- Dermabrasion
- Scar revisions
- Tattoo removal
- Hair loss
- Ear piercing

We ask *that you sign below to indicate your understanding of the preceding information. Each procedure/service will be discussed with you before the physician treats you.*

Patient Name (please print) _____

_____ _____

Patient Signature Date