OHIO SKIN CENTER

DERMATOLOGY • SURGERY • COSMETICS

Self-Pay Quote & Agreement

Treatment: _____ Quote: _____

Treatment: _____ Quote: _____

Due today: _____

_____ I understand that I will be responsible for a $250.00 deposit when scheduling appointments at the Ohio Skin Center.

_____ I understand that I will be responsible for all additional charges related to the services provided to me.

_____ I understand that I will be billed for any services that total an amount above the pre-paid deposit.

_____ I understand that the Ohio Skin Center will discuss a cost quote for services to be performed.

_____ _____

Patient Signature Date

_____ _____

Ohio Skin Representative Date

999 Brubaker Drive, Suite 3, Dayton, Ohio 45429

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