LAKEVIEW
Plastic Surgery

Alison M. Shore, MD
3000 North Halsted St.
Suite 707
Chicago, IL 60657
Tel: 773-883-8234
www.lakeviewplasticsurgery.com

Patient Agreement of Financial Responsibility

I, _____, acknowledge and understand that my bill for services I have requested and received will be sent to the insurance I have provided. Any unpaid portion including **deductible, co-pay, co-insurance, or rejected claim is my full financial responsibility**. It is my understanding that I will pay the entire balance in full once the insurance has settled the account.

Patient Signature _____

Date _____