

NORTHSHORE DERMATOLOGY CENTER, S.C.
PATIENT FINANCIAL POLICY

TINA C. VENETOS, M.D.

Licensed Dermatologist

REBECCA FEHLING, MS, PA-C

Licensed Dermatology Physician Assistant

CHRISTINA AVILINA, MS, PA-C

Licensed Dermatology Physician Assistant

Northshore Dermatology Center has contracts with many insurance plans. Please check with your insurance carrier to determine whether we participate in your specific plan.

If we are contracted with your plan, we will file a claim (for non-cosmetic services) to your insurance company. You will be responsible for any co-pays, deductibles, purchased products and/or non-covered services.

Returned checks will be subject to additional fees and interest charges (\$25 per check).

Balances older than 90 days will be sent to a collection agency.

If you do not have one of the plans which the practice is contracted, the total cost of the visit is required at the time of service.

A separate charge for pathology and lab work may be submitted to your insurance company in addition to the procedure itself. Any charges not covered by your insurance company will be your responsibility.

Many plans, including HMO and POS plans, require referral authorization from your Primary Care Provider (PCP) in order for your visit with us to be covered. If you did not obtain a referral prior to your appointment, you will be asked to pay at the time of service.

All laser and cosmetic appointments rendered in our office require payment in full at the time of service. We do not bill these services, even if your plan is one with which we are contracted, as they are deemed "elective" and not medically necessary.

For your convenience, we accept cash, checks, American Express, Visa, Master Card and Discover as payment options. If you have any question about coverage and/or payment, feel free to ask in advance of services being rendered.

At Northshore Dermatology Center, we are dedicated to providing you with the highest quality care, including privacy. We abide by HIPPA regulations to ensure patient confidentiality at all times. We protect the security and confidentiality of your personal information. Our most important asset is our relationship with you.

I hereby acknowledge that I have read this document and understand my financial responsibility for services provided for myself and other patients whose names I have provided to appear on my account with Northshore Dermatology Center.

Patient Name _____

Patient Date of Birth _____

Signed _____ **Date** _____