Dermatology Specialists of North Florida, P.A.

John P. Kartsonis, M.D. Jean H. McClintock, M.D.

Patient Financial Responsibility

- **YOU ARE RESPONSIBLE to ensure that both your referral and insurance are valid on the date of your visit to Dermatology Specialists of North Florida, P.A., and all treatment provided.** Our office participates with most major insurance plans and we make a good faith effort to ensure that we are in-network providers for all insurance accepted however, due to the rapidly changing healthcare market, **it is ultimately the patients' responsibility to verify that Dr. John Kartsonis and/or Dr. Jean McClintock are participating providers with your specific plan.** As a courtesy, our office will file your insurance claim with the information you provide us one time per visit; if we receive a denial or no timely response, you will be responsible for payment.

- **Co-payments and payment for cosmetic and non-covered procedures are collected on the date of service.** We accept cash, check, Visa, MasterCard, or Discover.

- **The fee for a missed appointment without one (1) working days' notice via phone call to the office is at least $25.00. The fee for a missed surgery/procedure without three (3) working days' notice is ½ the fee or at least $100.00.**

- **In the event your account is turned over to a collection agency or attorney for recovery, you will be responsible for all associated collection costs.**

- If applicable**, I request that payment of authorized Medicare benefits** be made to Dr. John Kartsonis and/or Dr. Jean McClintock for any services furnished to me by the practice of Dermatology Specialists of North Florida, P.A. I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits for related services.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTOOD MY FINANCIAL RESPONSIBILITIES AND THAT I AUTHORIZE MY INSURANCE COMPANY TO REIMBURSE DERMATOLOGY SPECIALISTS OF NORTH FLORIDA, P.A. FOR MY CARE.

Signature of Patient/Legal Guardian and Date_____

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