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DIPLOMATE, AMERICAN BOARD OF DERMATOLOGY
THE BARLOW BUILDING
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Patient Name: _____

- I understand that I will be responsible for today's services if a copy of my insurance card is not provided to the billing office by 5:00pm today.
- I understand that Dr. O'Neill participates only with Medicare. Should a waiver be necessary to process my claim, I take full responsibility for any denied charges.
- I understand that if my insurance requires the name of a referring physician, and I do not supply that information, I will be billed for any charges that are not covered by the insurance if this information is not supplied at the time of service.
- I understand that if payment is required, it is due at time of service and only Visa, MasterCard, Discover and exact cash is accepted.

Signature: _____

Date: _____