WELCOME TO ARIZONA DESERT DERMATOLOGY

PATIENT INFORMATION (Please Print)

Latest Revision: 9/16

NAME: Last	First	M.I.	A.K.A. (Nickname)

DATE OF BIRTH:	SSN:	GENDER M / F	RACE: ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic/Latino ☐ Black/African American ☐ Multiracial ☐ Hawaiian/ Pacific Islander ☐ White ☐ Decline to answer

MAILING ADDRESS:	ETHNICITY: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown Preferred Language:

CITY	STATE	ZIP	PRIMARY CARE PHYSICIAN:

HOME PHONE:	CELL:	WORK:	Marital Status:

CIRCLE ONE: WINTER / SUMMER ADDRESS (if different): CITY STATE ZIP

EMERGENCY CONTACT: RELATION: PHONE:

EMAIL ADDRESS:

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME:	POLICY #
NAME OF INSURED: (If other than patient)	GROUP #
BIRTHDATE OF INSURED:	RELATION TO PATIENT:
IS INSURANCE PROVIDED BY EMPLOYER: YES / NO	NAME OF EMPLOYER:

SECONDARY INSURANCE COMPANY NAME:	POLICY #
NAME OF INSURED: (If other than patient)	GROUP #
BIRTHDATE OF INSURED:	RELATION TO PATIENT:
IS INSURANCE PROVIDED BY EMPLOYER: YES / NO	NAME OF EMPLOYER:

Do you have a Power Attorney: Y/N
If yes, please give name:_____ phone:_____

I authorize you to discuss my medical records with the following individual (s)

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Patient Signature Authorizing Release:_____

ALL PATIENTS

- I acknowledge full financial responsibly for medical services rendered and I agree to pay in full at the time of service, or to make prior arrangements for payment. If my account is placed for collections, I acknowledge responsibly for associated collection expenses. A fee, determined by our collection agency, will be added to any balance turned over to collections. There will be a charge for canceled or broken appointments without 24 hours notice as follows: $20.00 established, $40 new, $50 cosmetic, and $100 for all surgery and Mohs appointments. There will be a $35 charge for all returned checks.
- We will bill your insurance as a courtesy to you. We will wait 60 days to remit payment. If it is not paid within this time, the total bill becomes due and payable in full by the person responsible for payment of this account. We suggest you work closely with your insurance to expedite payment. It is your responsibility to provide them with information requested. Please forward any information they may request.
- A written copy of the Privacy Practices for Arizona Desert Dermatology has been made available to me.
- I authorize you to take photographs of my medical condition to be used for educational purposes.

- I authorize Arizona Desert Dermatology to release my medical records to the doctor who referred me and to a doctor I am referred to. I further authorize the release of any information to my insurance company necessary for processing my claims.
- I request that the payment of benefits be made on my behalf to Arizona Desert Dermatology for and services furnished me by their providers.

Print Name_____ **Signature**_____ **Date**_____

******GET TO KNOW YOUR INSURANCE******

INSURANCE CONTRACTS:
Aetna
Blue Cross Blue Shield
GEHA (AFMC)
Humana (Medicare Replacement)
Medicare & Medicare Railroad
Phoenix Health Plan (Medicare Replacement)
Sierra Health & Life
Tricare
United Healthcare (NOT all policies)

NETWORK CONTRACTS:
Accountable Health
Aetna
AZ Foundation for Medical Care
Beech Street
Blue Cross Blue Shield
First Health
Health Smart
HMA/HMN
Intragroup
Managed Care Consultants
MultiPlan
PHCS

Contracted Insurances: co-pay's are usually applied to the office visit charge. Some insurances apply procedures done at the same visit to the in network deductible, co-insurance or another co-pay.
Non-Contracted Networks: charges are usually applied to your out of network deductible and co-insurance; however, you receive a network discount.
Insurance companies have their own rules and guidelines independently. If you are unsure how your insurance will process your claims, please contact your representative for clarification. **Our office does not guarantee nor take responsibility for how your insurance company processes your claims.**

Print Name_____ **Signature**_____ **Date**_____

MEDICARE PATIENTS ONLY

Provider's name: Arizona Desert Dermatology

I request that payment under the medical insurance program be made either to me or to the provider named above on any bills for service furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration or it's intermediaries or carries any information needed for this claim or any related Medicare Claim. I further permit a copy of this authorization to be used in place.

Print Name_____ **Signature**_____ **Date**_____