A to Z Dermatology

4540 E Baseline Rd Ste 109 Mesa, AZ 85206
1821 N Trekell Rd Ste 2 Casa Grande, AZ 85122
10503 W Thunderbird Blvd Ste 114 Sun City, AZ 85351
1343 N Alma School Rd Ste 135 Chandler, AZ 85224
6724 S Kings Ranch Rd Ste 104 Gold Canyon, AZ 85118

Office: (480) 982 – 3337
Fax: (480) 497 - 4580
www.atozdermatology.com

Dear Patient,

Welcome to A to Z Dermatology! Thank you for choosing us we would love to be your partner with your skin care needs. Our goal is delivering personalized, quality care to all of our patients. New patients we've included information to assist with your experience. Please, contact us at 480-982-3337 or visit our website at www.atozdermatology.com, if you have any questions.

New Patients: Please, arrive 15 minutes prior to your appointment time to allow enough time to fill out paperwork and allow staff to enter all information correctly into our Electronic Medical Records. Paperwork can be filled out or downloaded from our website www.atozdermatology.com located on the new patient tab and choose on line forms. Contact our office for any questions at: 480-982-3337.

Photo ID/Insurance Cards: Please bring your photo ID and insurance cards to your visit. We will need to scan them into your Electronic Medical Record.

Arriving Late to Appointments: If you arrive 15 min after your appointment time we may reschedule your appointment.

Cancellations and No Shows: Please, provide a minimum of 24 hour notice when canceling or rescheduling your appointment. Consistently missed appointments may lead to dismissal from the practice. We may also bill you $25.00 for any appointments that are missed or cancelled without 24 hour notice. We will give you a call and text message to confirm your appointment; however this is a courtesy and shouldn't be relied upon to remind you of your appointment.

Payment: We accept debit and credit cards only. *We do not accept cash or checks.*

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Copays, Deductible & Co-Insurance: Copays, Deductibles and Co-Insurance are due at the time of service. Any adjustments after the claim is processed, we will refund the difference.

Self-Pay: Payment is due in full at the time of service. Including services that are considered cosmetic.

Collections: Accounts placed in collection status, all prior balances are required to be paid in full prior to scheduling future appointments. All future patient responsibility such as co pays, deductibles and co-insurance will be due at the time of service or you will be rescheduled. Balances assigned to a collection agency will be charged 30-40% collection fee.

Payment Plans: We offer payment plans and hardship options. To inquire about our options contact us at 480-982-3337 choose the option for billing.

Biopsy/Pathology or Lab Samples: Specimens are sent to an outside lab and are billed separately from A to Z Dermatology. You may receive a statement from the outside lab and are responsible for payment directly to that facility.

Medical Records Request: A signed medical release form and $30.00 fee is required prior to the release of medical records. Medical records will be released within 7 business days. Please, inform us if medical records need to be expedited, we will make every effort to do so. This is not required for transfer of records to physicians that participate in your care, reports for your personal records or insurance companies to complete payment of an open claim.

Thank you for allowing us to be a partner in your skin care needs.

Sincerely,

Jayshri Gamoth, M.D.

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PATIENT FINANCIAL POLICY

Thank you for choosing A to Z Dermatology for your skin care needs. We're committed to providing quality and affordable health care. Our team works hard to ensure your paperwork if filed accurately and promptly.

INSURANCE: We participate with insurance plans, including Medicare. As a courtesy we will bill whichever insurance you have indicated. Please, help us maintain current and accurate information by filling out our forms completely, legibly, and informing us of any changes (i.e. address, phone numbers, name changes, medical insurance, etc.).

KNOW YOUR BENEFITS: All insurances including Medicare have different plans and benefits. Benefits are an arrangement between you and your insurance company. It's important to know what services are covered under your specific plan. Insurance plans have their own specific criteria for services they will and will not cover; and how frequently they will cover. It's impossible to know all of the many different employer group benefits from one employer to the next. Therefore, A to Z Dermatology cannot be held responsible for notifying the patient if a particular service is or is not covered. However, our staff will make every effort in assisting you with understanding your health benefits.

PROOF OF INSURANCE/ID: All patients are required to complete our patient information form. We must obtain a copy of your driver's license and a current valid insurance card. If you are unable to present your insurance card at the time of service, or are covered by an insurance plan which we are not contracted, it's required to pay in full for services in advance.

COPAYMENTS, COINSURANCE AND DEDUCTIBLES: All patient responsibility such as copays, coinsurance and deductibles must be paid at the time of service. This is the contractual agreement between you and your insurance company. Refusing to pay your patient responsibility may be considered a break of contract with your health plan. We may decline to see patients for non-emergent visits if patient responsibility is not paid at the time of service.

CLAIMS SUBMISSION: As a courtesy we will submit your claims to the insurance companies we are contracted with and assist you in any way that's reasonable to help get your claim paid. Your insurance may need additional information from you. It's your responsibility to comply within a timely manner.

NONPAYMENT: In the event your insurance company doesn't pay your claim within 60 days, the remaining balance will become your responsibility and a statement will be sent. Accounts that are 60 days past due may be turned over to a collection agency. Patients sent to collections will be discharged from the practice after 30days unless the balance is paid in full. Patients are notified by regular or certified mail that they have 30 days to establish alternative medical care. You can be seen at A to Z Dermatology for 30 days on an emergency basis.

NON-COVERED SERVICES: Your A to Z Dermatology provider may provide services that may not be covered with your insurance benefit plan. Patients or Guarantors are required to pay at the time of service for non-covered procedures not covered by your insurance plan.

PRIVATE PAY/SELF PAY: Payment is due in full at the time of service. No exceptions.

"NO SHOW" POLICY: Any patients that don't show for their **scheduled visit** and haven't called to cancel with the 24 hours will be charged $25.00. Any patient that does not show for their scheduled **surgery** appointment and hasn't called within 48 hours to cancel will be charged $300.00.

OUTSIDE PATHOLOGY, LAB FEES: Biopsy, Pathology and Lab specimens sent outside of our office are billed independently of A to Z Dermatology. You may receive a bill from the outside lab and will be responsible to pay that facility.

I have read and agree with the above Patient Financial Policy. I understand the terms and conditions outlined herein as confirmed by my signature below.

Patient or Responsible Party's Signature _____ Date Signed _____

Printed Patient's Name _____

Responsible Party's Printed Name (if applicable) _____

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PATIENT CONSENTS

CONSENT FOR TREATMENT

I authorize A to Z Dermatology LLC, it's employees and agents, including physicians, physician assistants, and other employees, to provide any healthcare services that my provider deems necessary to diagnosis and or treatment. The duration of this consent is indefinite and continues until revoked in writing. If a biopsy is performed, I authorize the Pathologist to send my specimen for a second opinion and or obtain special tests, if medically necessary to ensure and accurate diagnosis. I understand that addition costs may result and that I will be responsible for any remaining balance that is not covered by my insurance company, Medicare and or supplemental policy. I understand that by not signing this consent, the patient will not be provided medical care except in case of emergency.

CONSENT FOR PHOTOS

I understand during the course of my treatment, photographs may be taken for clinical and education purposes. Audio taping, videotaping, or photography is not allowed by non-staff members.

CONSENT FOR FILING INSURANCE CLAIMS

I understand A to Z Dermatology required your signature on file for claims submission to your insurance company, Medicare and or supplemental policy when an assigned claim is filed. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV). I also authorize A to Z Dermatology to appeal any denials to my insurance company, Medicare and or supplemental policy, on my behalf and authorize the release of any medical information to my insurance company, Medicare and or supplemental policy that is necessary for the processing of claims. I understand I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to A to Z Dermatology. I further

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I understand that should my account become delinquent; I will pay the collection and attorney's fees of A to Z Dermatology, if any.

CONSENT FOR ELECTRONIC PRESCRIPTION HISTORY

I understand that to officer the best patient care, A to Z Dermatology will retrieve my prescription history that has been ordered and filed through and HER system. I authorize A to Z Dermatology to import the prescription history obtained through an HER system into my electronic chart.

CONSENT FOR APPOINTMENT REMINDERS / THIRD PARTY COMMUNICATIONS

I authorize A to Z Dermatology to send me appointment reminders via SMS text messages, phone calls and emails. I understand that message/data rate may apply to messages sent by A to Z Dermatology under my cell phone plan. I authorize A to Z Dermatology and third-party collection agents to utilize all contact information I have provided in efforts to communicate regarding my account. I agree that affiliates may contact me through text messages, ring less calls and emails to provide me with my bill and to remind me to pay for services provided by A to Z Dermatology, in compliance with federal and state laws. I understand that I am under no obligation to receive automated notification and may opt out of these communications at any time by following the prompts in the reminder. Further, I may revoke my consent to receive billing and payment communication by affiliates.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy
(Patient Name)

of A to Z Dermatology NOTICE OF PRIVACY PRACTICES. This notice describes how A to Z Dermatology may use and disclose my protected health information, restrictions on the use of disclosure of my health care information, and rights I may have regarding my protected health information.

_____ _____
(Signature of Patient or Personal Representative) (Date)

_____
(Relationship to Patient)

Personal Representative (family members, attorney, etc.): I hereby authorize A to Z Dermatology and its employees to discuss send and or receive medical information to the following.

Please provide their names and phone numbers below:

1. Name _____ Relationship _____
   Phone# _____
2. Name _____ Relationship _____
   Phone# _____
3. Name _____ Relationship _____
   Phone# _____

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Communication

Authorization For Communication via Voice Mail	Phone Number
I hereby allow all non-cancerous test results, blood work results, and all other communication can be put in a voice message on the phone number indicated in the box.	( )_____ - _____

By signing below, I certify that I have read the above information and my questions concerning A to Z Dermatology policies have been answered. My signature signifies my understanding and agreement with the above information. The duration of this consent is indefinite until revoked in writing.

Patient Name		Patient DOB	
Parent/Legal Guardian Printed Name		Relationship to Patient	
Signature		Date	