Alta Dermatology Group
130 S. 63rd Street ~ Suite 114 ~ Mesa, Arizona 85206
480~981~2888

Patient name: (print)_____ Date of Birth:_____/_____/_____

OUR MISSION STATEMENT

Our mission is to respond to our community's dermatologic health care needs. Our staff is committed to our patients in providing accessible, caring and cost effective health care.

OUR FINANCIAL POLICY

If you are covered by a plan that we contract with as a participating provider we will file all claims to your insurance carrier for all covered services. Due to the large number of insurance plans and policies we only file selected secondary insurances. We encourage our Medicare patients to contact their supplemental insurances to set up coordination of benefits ("auto crossover") as we do not file for all Medicare supplement insurances.

As for minors, the parent or guardian accompanying the patient is responsible for all charges (please refer to the paragraphs below for more information). For established unaccompanied minors, non–emergency treatment will be denied unless written consent is provided by the parent or guardian.

Please help us serve you better by keeping your scheduled appointments and or cancelling at least 24 hours in advance.

All charges that are the patient's responsibility are due at the time of service. We accept cash, check, Visa, AMEX and MasterCard.

PLEASE READ and SIGN BELOW

I assign all benefits to which the patient or insured is entitled for my treatment and medical services provided to me to be paid directly to Alta Dermatology Group.

I am financially responsible for any co-pays, coinsurances, deductibles and all charges which are not covered by my insurance. All co-pays, procedures, coinsurances, deductibles are due at the time services are rendered. I understand that separate medical facilities may bill me directly for lab and pathology services.

I am responsible for all charges if it is determined that the information I have provided is not correct and that it is my responsibility to notify Alta Dermatology Group if there are any changes to my insurance and or contact information.

For amounts due after insurance has processed the claim; Alta Dermatology Group will only send 2 consecutive statements at 30 day intervals and the balance is due in full during that period. If my account remains delinquent past 60 days, it will be turned over to a collection agency and NO additional contact will be made by Alta Dermatology Group.

RELEASE OF INFORMATION: I hereby authorize Alta Dermatology Group to release information to my insurance company; for the purpose of obtaining payment for their services and to review activity related to their participation with my insurance plan.

Your signature below signifies that you have read each item and understand your responsibilities to Alta Dermatology Group.

_____ _____

Signature of Patient/Responsible party *Date*

_____

PRINTED name of Patient/Responsible party