

A Medical, Surgical, and Cosmetic
Z Dermatology
 to

1801 N. Trekeil Rd. Suite #5, Casa Grande, AZ 85222
 Office: (520) 374-2462 Fax: (520) 374-2467

Jayshri Gamoth, M.D.

In case of emergency

Name of friend or relative not residing with you _____
 Relationship to patient _____ Address _____
 Day phone# (____) _____ Evening phone# (____) _____

Pharmacy Information

Pharmacy Name _____
 Address _____
 Phone number# (____) _____ Fax number# (____) _____

How did you hear about AZ Dermatology?

Newspaper
 Radio
 Magazine
 Physician
 Family/Friend
 Yellow Pages
 TV
 Direct Mail
 Other: _____

Release of information and assignment of benefits

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Responsible Party Signature: _____ Date ____/____/____

Payment Policy

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any un-met deductible, non-covered services and co-payments. Please note that the patient is responsible for any/all charges not paid for by their insurance company. Prior authorization does not guarantee payment of claims. **If you must cancel or reschedule an appointment please do so at least 24 hours before the scheduled appointment time to avoid a possible late cancellation fee that is not covered by insurance.** Your signature below signifies your understanding and willingness to comply with these policies.

Patient Signature: _____ Date ____/____/____

Medicare and Medicare HMO Patients, please fill our "Medicare Patient Information" form.

For Office Use Only:	
<input type="checkbox"/> Attach a copy of patient's insurance card or cards (front and back)	Staff Initials _____
<input type="checkbox"/> Verify form is filled out completely	Staff Initials _____