SKIN and CANCER CENTER of Arizona

An Established Tradition of Medical Excellence

We are pleased you have chosen the Skin & Cancer Center of Arizona for your dermatologic care.

PATIENT INFORMATION FORM
All new patients must fill out a PATIENT INFORMATION FORM when checking in. Additionally, you will be asked to fill out an update when there has been a change in your address, insurance or if our office has made changes to an existing form. **It is extremely imperative that these forms be filled in completely.**

REFERRALS
It is your responsibility to know if your insurance plan requires that you obtain a referral from your primary care physician before coming to our office for treatment. Be sure that your primary care physician knows all of your dermatologic complaints so that he or she can fully complete the referral form. We are authorized to treat only those conditions listed on the referral form. If you are an established patient and have previously received a referral to our office, please be sure to check on the expiration date and or the number of visits authorized, to be certain you still have a valid referral. Without the appropriate referral form signed by your primary care physician, we are not authorized to see you.

CANCELLATION POLICY
A **$25.00** fee will be charged to all patients who do not call to cancel or reschedule their appointment at least 24 hours prior to their appointment time. A **$75.00** fee will be charged to all patients who do not call to cancel or reschedule their surgery appointment at least 24 hours prior to their appointment time. When a patient does not show for a scheduled and confirmed appointment, other patients in need of medical care are unable to be seen. It is your responsibility to keep track of your appointments.

NON-COVERED SERVICES
It is the responsibility of the patient to know and understand the limitations of your insurance coverage. If a service rendered by your provider is not covered by your insurance plan you will receive a bill for these services.

CO-PAYS
Co-payments and any additional balance on your account are due at check in.

We look forward to providing your dermatologic care.
PATIENT ACKNOWLEDGEMENT
I have read and agree to the above terms:

_____
Print Patient Name

_____ _____
Patient/Guardian Signature Date

 AD - 030 REV 06/19
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