

Paradise Valley Dermatology
Mark A. Blair, M.D.

12251 N. 32nd Street, Suite 12
Phoenix, AZ 85032
(602) 971-0950

Welcome to Paradise Valley Dermatology

Enclosed you will find Paradise Valley Dermatology's patient information & registration packet. It is important that you complete all forms in this packet and bring them completed to your initial appointment or you may fax it to (602) 992-4971 prior to your appointment.

We strive to stay on schedule because your time is valuable to us. Staying on schedule also provides yourself enough time to check in, have your IDs scanned into the system and give our reception personnel time to enter your information if you have not faxed it to us prior to the appointment. Please plan to arrive 15 minutes prior to your scheduled time for your initial visit.

We look forward to caring for you in our practice. Please call our office if you have any questions at (602) 971-0950.

Sincerely,

Paradise Valley Dermatology

SOME IMPORTANT REMINDERS REGARDING YOUR SCHEDULED APPOINTMENT

- **Late Arrivals** – If you are running late, every attempt will be made to accommodate you. Your treatment may need to be rescheduled in consideration of other patients with already scheduled appointments.
- **24 Hour Cancellation Notice** – If you have to cancel an appointment, please try to provide us with at least 24 hours notice. Please contact our office at (602) 971-0950 as soon as possible to cancel or reschedule your appointment. We will attempt to contact you by phone with a courtesy reminder 2 weeks and 1-2 days prior your appointment.
- Please be aware there is a high demand for dermatology appointments and that a 24 hour cancellation notice allows us the opportunity to offer that appointment to another patient. ***A cancellation less than 24 hours or a no call/no show could result in a \$35.00 assessment that will be paid at the time of the next visit. Late cancellations due to illness or family emergency are excluded from this policy.***

Payment Policy and Insurance

Insurance: We are a provider for many health insurance plans so please verify with your insurance carrier that Paradise Valley Dermatology is a contracted provider with your insurance. We will be happy to submit to your insurance carrier(s) as a courtesy after services are rendered so it is important that you provide us with updated, complete and accurate information at every visit.

As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. Not all services are covered in all insurance contracts. **You are responsible for all co-payments, co-insurance, deductibles and any unpaid or denied services not covered by insurance.**

Prior Authorizations: Your insurance plan may require you to obtain from them a pre-authorization or a referral prior to seeing a specialist. It is the insured's responsibility to obtain the referral authorization from your insurance carrier and provide that information to our billing department on the date of service. Your insurance plan booklet should explain the details of your plan.

Proof of Insurance/Identification: All patients must complete the registration form at time of service. We also require a copy of a valid photo ID such as state license and a copy of your current insurance card as proof of insurance.

I have read and understood the Appointment and Financial policies of Paradise Valley Dermatology.

Print Name: _____

Patient or Guardian Signature: _____ Date: _____

If **Guardian** representative, describe relationship: _____

Paradise Valley Dermatology

Authorization of Use and Disclosure of Protected Health Information

This notice describes how health information about you as a patient of this practice may be used and disclosed and how you can get access to your Protected Health Information. Please review this notice carefully.

Our practice is dedicated to maintaining the privacy of your Protected Health Information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and privacy practices that we maintain in our practice concerning your PHI. We must provide you with the following important information:

- How we may use and disclose your Protected Health Information (PHI)*
- Your privacy rights in your PHI*
- Our obligations concerning the use and disclosure of your PHI*

Paradise Valley Dermatology reserves the right to revise its Notice of Privacy Practices at anytime.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize Paradise Valley Dermatology to release any medical information including diagnosis, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: calls pertaining to my clinical care, lab results, insurance, legal, and at times when the doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I have the right to request that Paradise Valley Dermatology restrict how it uses or discloses my PHI however, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I have the right to inspect and obtain a copy of the PHI that may be used to make decisions about me, including patient medical records and billing records. You must submit your request in writing to the attention of the Practice Administrator.

If I do not sign this consent, Paradise Valley Dermatology may decline to provide treatment to me. You are entitled to receive a paper copy of this notice at any time. To obtain a copy or if you have any questions about this notice, please contact our Practice Administrator at (602) 971-0950.

Patient Name (Please Print)

Date of Birth

Patient or Guardian Signature

Date

APPOINTMENT REMINDERS, LABORATORY RESULTS, BILLING ISSUES

This office may need to notify you of any changes in your scheduled appointment, to inform you of your lab results and/or physician instructions and to discuss billing issues pertaining to your services.

Please indicate how you would like to be notified with the information:
(Check all that apply)

_____ Home Telephone # _____

_____ Cell Phone # _____

If you have an answering machine, may we leave messages regarding appointments, lab results and/or other information pertinent to your healthcare and/or payment for your services provided by Paradise Valley Dermatology?

_____ Yes _____ No

_____ Work Telephone

_____ Work Voicemail

_____ You may discuss any of my medical information with the following emergency contact:
(If applicable)

_____ Name

_____ Relationship

_____ Telephone