

IRONWOOD DERMATOLOGY, P.C.

PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

PATIENT NAME: _____

PAYMENT POLICY:

HMO, PPO or other managed care: You will be responsible for paying your annual deductible, co-payment, coinsurance and charges for any elective or cosmetic procedures.

Out of Network insurance carriers: We will file claims for patients covered by private or commercial plans in which our physicians are not providers. Please be aware that charges are not subject to any sort of contractual deduction. Additionally, insofar as we have no contractual relationship with these carriers, we are unable to appeal any adverse claims decision. Any outstanding balance is the responsibility of the patient or guarantor and will be billed to patient or guarantor 30 days after the claim is filed.

Patient, legal guardian or responsible party signature:

_____ DATE _____

Please bring this completed form to your first appointment, or fax it to: 520-618-1636