

CERTIFIED DERMATOLOGY

INFORMED PATIENT CONSENT

PLEASE INITIAL EACH LINE ITEM AND SIGNATURE AT THE BOTTOM OF THE PAGE

_____ I give my permission for the provider and staff of Certified Dermatology to treat me as deemed necessary as per their professional judgement.

_____ I understand that medical care requires my cooperation, and I will follow my providers orders and prescriptions. I will make and keep appointments for follow-up care and call the office to note any changes or concerns with my condition.

_____ I authorize my provider to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical care to their party payers, including Medicare.

_____ I authorize and request that my insurance company, in lieu of reimbursing me directly, pay to the provider or medical group any benefits for services rendered.

_____ I understand that my medical insurance carrier may pay less than the actual bill for services. I agree that I may be responsible for payment for all services rendered on my behalf or my dependents.

_____ I understand I may be billed by an outside laboratory for work that is performed in this office, if my insurance company does not have a contracted lab or facility, or if services are not covered by my insurance.

_____ I hereby certify that I have read the foregoing CONSENT and fully understand the contents thereof.

Patient Name or Legal Guardian/Patient Representative (**Print**)

Date

Signature of patient or patient's legal guardian/representative

Witness/Date