Informed Patient Consent

_____ I give my permission for Dr. Blatnoy and staff of Dermatology and Skin Cancer Surgery Center to treat me as deemed necessary in the exercise of their professional judgment.

_____ I understand that medical care requires my cooperation.

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

_____ I authorize my doctor to release any information, including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such medical care to third party payers, including Medicare. Consistent with HIPPA regulations, any release will be limited to only those records required to obtain payment.

_____ I authorize and request that my insurance company, in lieu of reimbursing me directly, pay to the doctor 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 of 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 company.

_____I received and read Notice of Privacy Practices.

_____ _____

Patient Name (Print) Date

_____

Signature of patient or patient's legal guardian