



Advanced Dermatology & Cosmetic Surgery

Informed Patient Consent

_____ I give my permission for the Physicians and staff of *Advanced Dermatology & Cosmetic Surgery* to treat me as deemed necessary in the exercise of their professional judgment.

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

_____ I authorize my doctor 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 third party payers, including Medicare.

_____ 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.

_____ In the event that I chose to provide *Advanced Dermatology & Cosmetic Surgery* (“ADCS”) with my e-mail address, I hereby authorize ADCS to contact me using the e-mail address(s) I provide, and agree to allow ADCS to continue to contact me using e-mail until I advise ADCS, in writing, and that they can no longer contact me using e-mail. In return for allowing ADCS to contact me using e-mail, ADCS promises not to release, sell or otherwise distribute any e-mail address(s) I provide to any other person or entity without my express written authorization.

_____ I authorize the physician[s], mid-level providers or staff of *Advanced Dermatology & Cosmetic Surgery* to educate me regarding skin care products or devices suitable for my disease state or diagnosis. I understand that I can opt-out from receiving this information at any time by writing to the Privacy Officer, 2600 Lake Lucien Drive, Suite 180, Maitland, FL 32751.

_____ 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