

PATIENT CONSENT FORM



_____ PATIENT NAME

_____ DOB

Kathleen W. Judge, M.D.

Medical Director

*Diplomate American Board of Dermatology
Dermatology and Dermatologic Surgery*

_____ I hereby authorize Central Florida Dermatology Associates' (CFDA) designated medical staff to leave a *detailed message of my laboratory results* at the following number: _____

_____ I hereby authorize Central Florida Dermatology Associates' designated medical staff to take *photographs as considered necessary for my medical records*. I understand that these photographs will become part of my medical record and may be shared with other medical professionals.

_____ I understand that when tissue is sent to a pathology lab for processing and examination, I (or my insurance company) *will be billed separately by the lab*. For any questions regarding lab billing, please contact the lab directly.

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

_____ I understand that there are *medical procedures that may be necessary as part of my treatment*. The following procedures are commonly performed in a Dermatology office:

- Skin biopsy for diagnostic purposes
- Removal of acne lesions or cysts
- Treatment of malignant lesions and/or pre-malignant lesions, such as Actinic Keratoses (AKs)
- Treatment of benign lesions, such as seborrheic keratoses (SKs), warts, moles, skin tags, hemangioma, telangiectasia, brown spots, or other similar benign growths
- Injection of medications into the skin or subcutaneous tissue
- Incision and drainage of abscesses or boils

These are considered minor medical procedures, but they do have associated risks, which may include, but are not limited to: bleeding, infection, scarring, skin color or texture change, numbness, slow healing, allergic reactions, no improvement or partial response to treatment, and/or recurrence. These conditions may be either temporary or permanent. Some of these procedures may require the utilization a local anesthetic and/or the placement of sutures.

_____ I understand that I have the right to refuse treatment at any time without explanation.

_____ I understand that the response to medical treatment cannot be guaranteed. Additional treatment may be required at additional fees.

_____ I acknowledge that I have received a copy of the CFDA Notice of Privacy Practices as required by Federal Law.

I have read and understand the above statements and hereby request and consent to medical care by Central Florida Dermatology Associates, Kathleen W. Judge, M.D. and her designated medical staff.

Signature of Patient or Legal Guardian

Date

CFDA Representative

Date