PATIENT CONSENT FORM

Please fill out the following:

I hereby authorize Central Florida Dermatology Associates’ (CFDA) designated medical staff:

- to leave detailed information regarding my appointments, lab results (benign only), medication, and other medical information at the following number: ____________________________
- to take photographs as considered necessary for my medical records. I understand these photographs will become part of my medical record and may be shared with other medical professionals.
- to release all records necessary to my insurance company, attorney, and/or other referring physicians.

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.
- 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. I will call the office to note any concerns or changes in my condition or contact information.
- 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.

These are considered minor 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 of a local anesthetic and/or the placement of sutures.

- I have the right to refuse treatment at any time without explanation.
- the response to medical treatment cannot be guaranteed. Additional treatment may be required at additional fees.
- I assign and transfer payment of medical benefits from my insurance to: Central Florida Dermatology Associates.
- IT IS MY RESPONSIBILITY TO MAKE SURE MY INSURANCE PLAN IS IN NETWORK. Although I may have insurance, I am financially responsible for all treatments/procedures/surgeries performed in the office. I am responsible to know and understand my insurance coverage including copays and deductibles.
- if my account becomes overdue and goes to collection, I agree to pay the additional collection fee of up to 30%.

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 ____________________________