CONSENT FORM

PLEASE INITIAL EACH LINE ITEM

_____ I give my permission for the Physicians and staff of *Florida Dermatology and Skin Cancer Centers* to treat me as deemed necessary in the exercise of their professional judgment.

_____ The most commonly encountered procedures in a Dermatology office are skin biopsies/cryotherapy/skin lesion removal/curettage/ and administration of local anesthesia. Each procedure has a small risk of scarring that may or may not be noticeable (common), mild pain (common), infection (uncommon), bleeding (rare), or allergic reaction (rare). I understand that a photographic image will be taken of any biopsy or surgery site performed for the sole purpose of identification of said site and insurance claims. I expressly consent to having said photograph taken. **If you are allergic to any type of local anesthesia you must inform your provider immediately. **

_____ I understand that *Florida Dermatology and Skin Cancer Centers* employs Advanced Registered Nurse Practitioners (ARNP) and Physician Assistants (PA) and I am scheduled with them, I agree to see them instead of a physician, but that I may always request an appointment with a physician.

_____ 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 understand that 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 will notify my provider of any special requests on sending pathology or specimens to specific labs, and understand that it is my responsibility to notify the provider each time I have an appointment.

_____ I authorize the physician(s), mid-level providers, aestheticians or staff of *Florida Dermatology and Skin Cancer Centers* to educate me regarding skin care products or devices suitable for my disease state or diagnosis. I understand that I opt-out from receiving this information at any time writing to the Privacy Officer, 1450 6th St. SE, Winter Haven, FL 33880.

_____ In the event that my account must be turned over to a collection agency, I understand that a $15.00 collections fee will be added to my account.

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

_____ _____

Patient Name of Legal Guardian/Patient Representatives Print Date

_____ _____

Patient Name of Legal Guardian/Patient Representatives Signature Date