CAROLINA DERMATOLOGY
OF GREENVILLE

## Acknowledgments

**Consent to Treatment:**

By reading and signing this document, you, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of photography, lab and pathological studies) as ordered or approved by your attending physician(s), or healthcare professional assigned to your care. You acknowledge and consent to the following: While routinely performed without incident, there may be material risks associated with any procedure. If you have any questions concerning these procedures, you will ask your physician(s) or provider to provide you with additional information. You also understand your physician may ask you to sign additional Informed Consent documents relating to specific procedures.

**Your Contact Information and Consent for Communication:**

Please provide phone numbers and email address where we may contact you:

Cell: _____ Home: _____ Work: _____

email address: _____ *Note: An automated appointment reminder may call or text the numbers listed. You will have the option to opt out for future reminders.*

Please indicate which, if any, of the above we may leave a voice and/or text message (other than appointment reminders) related to your care: _____.

**Release/Disclosure of Information:**

Other than yourself, with whom may we discuss your medical information? *Note: You must notify us in writing if you wish to change this designation at any time.*

Name: _____ Relationship to you: _____ Contact #: _____

**Emergency Contact Information:**

Name: _____ Relationship to you: _____ Contact #: _____

**Financial Responsibility:**

It is your responsibility to provide accurate insurance information to our office, and we will file claims in a timely fashion. You agree to pay co-payments or self-pay amounts at the time of service, and understand that ultimately, you are responsible for payment of services based on the insurance explanation of benefits (EOB) and agree to pay any balances that are billed to you. Payment for cosmetic service will be made at the time of service.

You authorize the release of all necessary information to your insurance company, health plan or other entity (third party payor) which may be responsible for paying for your care, and direct all payors to pay benefits due for such care directly to Carolina Dermatology, PA, and assign such sums to them. You understand this authorization and assignment of benefits shall remain valid unless you provide written notice of revocation to Carolina Dermatology, PA and the third-party payor; however, such revocation shall not pertain to information released and/or charges incurred prior to such revocation.

**Notice of Privacy Policy:**

The Notice of Privacy Policy has been made available to me relative to how my Protected Health Information (PHI) may be used and my rights regarding my PHI.

By signing this document, you certify that you have read and understand its contents and that information provided by you is accurate and complete. A copy of this document may be utilized the same as the original.

**Patient Signature: _____**

**Print Patient Name:_____**

**Patient DOB:_____/_____/_____ Today's Date:_____/_____/_____**

11/7/24jr

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