Certified
Dermatology

Phone:732-456-7777
NJDermDoc.com

INFORMED PATIENT CONSENT

PLEASE INITIAL EACH LINE ITEM AND SIGNATURE AT THE BOTTOM OF THE PAGE

_____ I give my permission for the provider and staff of Certified Dermatology 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 providers' orders and prescriptions. I will make and keep appointments for follow-up care and call the office to note any changes or concerns with my condition.

_____ I authorize my provider 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 their party payers, including Medicare.

_____ I authorize and request that my insurance company, in lieu of reimbursing me directly, pay to the provider 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 for all services rendered on my behalf or my dependents.

_____ I understand that every effort will be made to use the credentialed lab for your insurance company. However, there may be times that an outside lab may need to be used in order to diagnose your condition more accurately . It may be , that you may be billed by an outside laboratory for work that is performed in our office.
Your insurance company may or may not cover this expense. This will not be done unless it is absolutely necessary in our opinion.

_____ 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