Dermatology Treatment & Research Center, P.A.

Consent to Treat

IF ADULT:
I hereby authorize the employees and agents; including physicians, of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physicians' choice.

IF MINOR CHILD:
I hereby consent & authorize the employees and agents; including physicians, of this medical office to evaluate and treat my minor child, ____. I understand that this authorizes the person(s) named herein to consent to medical and surgical procedures and immunizations for the child named herein.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in case of emergency.

______________________________________ ____________________

Signature of Patient or Parent/Legal Guardian Date

____

Printed name of person signing and relationship to patient

Financial Responsibility

I hereby authorize payment of medical benefits to go directly to Dermatology Treatment & Research Center, P.A. and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to Dermatology Treatment 7 Research Center, P.A. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expense of Dermatology Treatment 7 Research Center, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

______________________________________ ____________________

Signature of Patient or Parent/Legal Guardian Date

____

Printed name of person signing and relationship to patient

Patient name: ____ Chart #________________