# PATIENT CONSENT FORM

Central Florida DERMATOLOGY ASSOCIATES

**KATHLEEN W. JUDGE, M.D.**
**MEDICAL DIRECTOR**
DIPLOMATE OF THE AMERICAN BOARD OF DERMATOLOGY
DERMATOLOGY AND DERMATOLOGICAL SURGERY

PATIENT NAME _____ DOB _____

## 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
  - Injection of medications into the skin or subcutaneous tissue
  - Incision and drainage of abscesses or boils
  - 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