Date: _____

COLUMBIA SKIN CLINIC

Patient Consents

Please initial each and sign below.

_____ 1. Communication Consent | Messages from Columbia Skin Clinic may be left for me at the following:

□ *Home* □ *Cell/Text* □ *Work*

List anyone with whom we may discuss your personal, medical, or financial information, i.e. family members or friends. The identity of these designated parties will be verified prior to the release of any information.

Name: _____ Relationship: _____ Phone: __(___)_____

Name: _____ Relationship: _____ Phone: __(___)_____

_____ 2. Consent to treat a minor (if 18 years of age of younger) **|** I (We) the undersigned parent(s) or legal guardian of _____, a minor, do hereby authorize and consent to medical treatment rendered under the supervision of any member of the medical staff. It is understood that this authorization is given to provide authority and power to render care, which the aforementioned provider in the exercise of his/her best judgment may deem advisable. A minor, by law, must be accompanied by a parent/guardian on the first scheduled appointment. This consent shall remain effective until one year from the date of this form.

Parent/Guardian Name: _____ *Parent/Guardian Signature:* _____

_____ 3. Patient Consent for Medical Photography | I give my consent for medical photographs to be made of me (or for the person for whom I am the legal guardian). I understand that these images will be stored in the private, secure medical record with controlled access mandated by the Privacy Rule.

_____ 4. Patient Information Consent | I have read and understand Columbia Skin Clinic's Notice of Information Practices. I understand that Columbia Skin Clinic will use and/or disclose my personal health information (PHI) for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment/payment. I understand that I have the right to restrict how my PHI is used if I notify the practice of my wishes. I understand that Columbia Skin Clinic will consider requests for restriction on a case-by-case basis but is not legally bound to comply with requests for restrictions. I understand that Columbia Skin Clinic does not allow the use of PHI for the purposes of marketing, fundraising, solicitation, or research studies. I hereby consent to the use and disclosure of my PHI for the provision of treatment facilitation of payment, evaluation of service quality, or administrative operations.

_____ 5. Patient Portal Consent | I authorize Columbia Skin Clinic to enable my patient portal by emailing me a link to access my personal health information. I understand that it is my responsibility to notify Columbia Skin Clinic if there is a change in my email account or I feel that my secure password has been breached.

*PATIENT EMAIL ADDRESS (please print):*_____

_____ 6. Practice Policies Acknowledgement | I authorize treatment by the Columbia Skin Clinic provider(s). My signature below authorizes the release of my medical information to any physician involved in my medical care, any insurance company through which I claim benefits, and any pharmacy of my choosing. I authorize Columbia Skin Clinic to import my current prescription list from Surescripts if it is available. I further authorize the assignment of all medical benefits to which I am entitled to Columbia Skin Clinic.

_____ *We wish to establish optimal relations with our patients and avoid misunderstanding regarding our payment and cancellation policies. Payment is required for all services at the time they are rendered unless you are enrolled in our AutoPay program. As a note, any returned check will immediately be sent to the county solicitor. For those patients, applicable copayments and deductibles will be collected. Any amount that your insurance company deems your personal responsibility is due from you. Furthermore, you authorize electronic communications from Columbia Skin Clinic to you regarding any outstanding balances. Any balances past 30 days will be sent to collections if a payment plan is not established.*

_____ I understand that for cosmetic procedures a non-refundable consult fee deposit is required at the time of scheduling. We accept payment in the form of cash, check, or credit card. I understand that a minimum notice of two (2) business days is required to cancel an appointment for cosmetic procedures. For Profound, CORE, and TruSculpt 3D, I understand that a minimum of one (1) week notice is required to cancel. Failure to provide this adequate cancellation notice results in a no-show infraction and forfeiture of deposit. I also understand that three (3) no-show infractions may result in dismissal from the practice.

Your signature below signifies that you have read and understand the above consents and policies.

Patient Name: _____ DOB: ___/___/___ Signature: _____ Date: ___/___/___

(If under 18 years of age, a responsible party must sign.)