

**BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THESE DOCUMENTS:**

- **2022 CERTIFIED DERMATOLOGISTS CONSENT, FINANCIAL AGREEMENT, CONSENT TO TREATMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION**
- **CERTIFIED DERMATOLOGISTS NOTICE OF PRIVACY PRACTICES**

Adult Patient, Parent, Guardian, or Power of Attorney Agent:

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name of Patient (if different from above, i.e. child or Power of Attorney Principal):

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