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

- **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):

_____