

**PATIENT ACKNOWLEDGEMENT AND CONSENT**

On behalf of myself or my minor child or other patient named below, I acknowledge and consent to the statements made in this form. Changes or alterations to this form are not binding on Anthony R. Elias, M.D. and Christine C. Tam, M.D., LLC (referred to as “CERTIFIED DERMATOLOGISTS” in this form).

**Consent to Health Care Services:** I am requesting that health care services be provided to me (or my minor child or the patient named below) at C CERTIFIED DERMATOLOGISTS. I voluntarily consent to all medical treatment and healthcare-related services that the caregivers at CERTIFIED DERMATOLOGISTS consider to be necessary for me (or the patient named below). CERTIFIED DERMATOLOGISTS is not responsible for any outcome from refusing such treatment or services. These services may include diagnostic, therapeutic, imaging, and laboratory services, including HIV testing. If I want any HIV testing to be performed anonymously, I will tell my CERTIFIED DERMATOLOGISTS caregiver. I consent to the ordering of blood samples for testing of communicable diseases including HIV and Hepatitis if a healthcare worker has been exposed to my (or the below-named patient’s) blood or bodily fluids. I am responsible for informing my caregiver of possible pregnancy before examination or treatment. I am aware that the practice of medicine and surgery is not an exact science; no guarantees have been made to me about the results of treatments or examinations.

I understand that CERTIFIED DERMATOLOGISTS may provide certain services by remote telehealth technology. Such telehealth services involve a health provider who is at a site remote from my location at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription. Further, I understand that I may have to travel to see a health provider in-person for certain diagnosis and treatment matters.

**Financial Responsibility:**

a. Subject to applicable law and the terms and conditions of any applicable contract between C CERTIFIED DERMATOLOGISTS and a third-party payer, and in consideration of all health care services rendered or about to be rendered to me (or the below named patient), I agree to be financially responsible and obligated to pay CERTIFIED DERMATOLOGISTS for any balance not paid under the “Assignment of Benefits/Third Party Payers” paragraph below or,

b. Subject to applicable law and in consideration of all healthcare services rendered or about to be rendered to me (or the below-named patient), I agree to be financially responsible and obligated to pay CERTIFIED DERMATOLOGISTS for the patient balances due.

c. I agree to pay CERTIFIED DERMATOLOGISTS at the time of service any applicable and actual or estimated copayment or coinsurance for the healthcare services rendered during the visit(s) at CERTIFIED DERMATOLOGISTS. I assume responsibility for determining in advance whether the services provided to me, or the patient named below, are covered by any private or governmental third-party payer. I will notify CERTIFIED DERMATOLOGISTS of any changes in my insurance and contact information and any necessary pre-certifications or referrals. I agree to pay all reasonable attorney fees, collection agency costs and/or fees associated with the collection of any unpaid balance.

**Assignment of Benefits/Third-Party Payers:** In consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I hereby assign to CERTIFIED DERMATOLOGISTS all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding CERTIFIED DERMATOLOGISTS’ regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. A list of usual and customary charges is available upon request. I authorize CERTIFIED DERMATOLOGISTS to request a review or file an appeal on my behalf to challenge a determination of benefits or denial of payment made by a third-party payer related to services and care provided. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third-party payer.

**Patient Rights and Responsibilities:** I have received a copy of the Certified Dermatologists Patient Rights and Responsibilities brochure.

**Uses and Disclosures of Health Information:** I have received Certified Dermatologists’ Notice of Privacy Practices. The Notice of Privacy Practices explains how CERTIFIED DERMATOLOGISTS may use and disclose confidential health information that identifies me (or the below-named patient). I consent to let CERTIFIED DERMATOLOGISTS use and disclose health information about me (or the below-named patient) as described in the Notice of Privacy Practices. In doing so I consent to the release of my (or the below-named patient’s) health information and financial account information to all third-party payers and/or their agents that are identified by CERTIFIED DERMATOLOGISTS, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent CERTIFIED DERMATOLOGISTS or provide assistance to CERTIFIED DERMATOLOGISTS for the purposes of securing payment from all parties who are potentially liable for payment for my (or the below named patient’s) health care, including for substance abuse, psychiatric care, or HIV, if applicable. I can revoke my consent in writing at any time except to the extent that CERTIFIED DERMATOLOGISTS has already relied on my consent. I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to CERTIFIED DERMATOLOGISTS in the past, present, or future, text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from CERTIFIED DERMATOLOGISTS and its affiliates, clinical providers, and business associates, along with any billing services, collection agencies, agents, or other third parties who may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered. I understand this consent to communications is not required to receive services from CERTIFIED DERMATOLOGISTS or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at anytime. I agree that CERTIFIED DERMATOLOGISTS may photograph or record me (or the below-named patient) for the purposes described in CERTIFIED DERMATOLOGISTS’ Notice of Privacy Practices which I have received. I will be asked to give advance written consent if I can be identified by such photographs or recordings and they are to be used or disclosed outside of CERTIFIED DERMATOLOGISTS for a different purpose. I may ask that any such filming or recording be stopped at any time.

**Clinical Research:** I consent to having my medical records and photos to be released for research and publication in print and online as long as my (or the below-named patient’s) identity is not disclosed.

**Valuables/Limitation of Liability:** I understand that I should not bring valuables (cell phone, electronic devices, medical equipment, jewelry, money, irreplaceable documents, etc.) with me to CERTIFIED DERMATOLOGISTS. If I choose to bring valuables to CERTIFIED DERMATOLOGISTS, I AGREE THAT CERTIFIED DERMATOLOGISTS SHALL NOT BE RESPONSIBLE FOR VALUABLES, even if I (or the patient named below) give(s) them to CERTIFIED DERMATOLOGISTS personnel. I also understand that CERTIFIED DERMATOLOGISTS may tell me not to use a valuable at anytime. Items in CERTIFIED DERMATOLOGISTS’ Lost and Found are given to charity after 30 days.

By signing below, I am indicating that I have reviewed, acknowledge, and consent to the terms described above.

Patient Name:	Name of Responsible Party Providing Consent (if applicable):
Signature of Patient or Responsible Party:	Relationship of Responsible Party to Patient (if applicable):
Date/Time:	