CONSENT FOR TREATMENT / AUTHORIZATION

I give my permission for the doctor(s) and staff of *Dermatology and Cosmetic Surgery of Dublin, Inc.* to treat me, including any biopsy or procedure(s), as deemed necessary in the exercise of their professional judgment.

I understand that medical care requires my cooperation, and I will follow my doctor's orders and prescriptions.

I will make and keep appointments for follow-up care and call the office to note any changes or concerns in my condition.

I authorize my doctor to release any medical information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical care to third party payers, including Medicare.

I authorize and request that my insurance company, in lieu of reimbursing me directly, pay to *Dermatology and Cosmetic Surgery of Dublin, Inc.* any benefits for services rendered.

I understand that my medical insurance carrier may pay less than the actual bill for services. I agree that I may be responsible for payment of all services rendered on my behalf or my dependents.

I understand that I may be billed by an outside laboratory for work that is performed in this office, if my insurance company does not have a contracted lab or facility, or if services are not covered by my insurance company.

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PRINT PATIENT NAME

____ ________________________
Patient Signature (Parent Signature if Patient is a minor) *Date*