Sunshine State DERMATOLOGY AND SKIN CANCER CENTER

CONSENT FOR TREATMENT

General Consent: I hereby represent that I am over the age of 18 or that I am the parent/legal guardian of the patient being treated. Misrepresenting my age or my legal guardianship of the patient may violate federal and state health and privacy laws.

Further, by signing this form, I represent that any consent or form signed by myself or the minor has the consent of all interested parties involved in the care of the minor.

I hereby consent to medical, cosmetic and surgical treatment by Dr. Greenberg and any other services rendered during my visit with Sunshine State Dermatology and Skin Cancer Center. Common services include physical exam, diagnostic testing such as lab draws and skin biopsies, wart and brown spot treatment, surgical excisions and cosmetic injections.

In order to ensure that you understand all aspects of your visit, you are encouraged to ask any questions or clarify any procedures prior to them being performed. Dr. Greenberg will answer any questions and discuss any procedures, concerns and goals with you regard to the benefits, methods, alternatives, consequences, risks, and possibility of additional charges. You may withdraw consent to a procedure at any time. With any procedure, there are risks involved which include, but are not limited to scarring, discoloration, infection, bleeding, and nerve damage.

I recognize that the practice of medicine is not an exact science and acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures. I do not impose any limitations on Sunshine State Dermatology and Skin Cancer Center and its staff. I understand that I should discuss any questions or concerns with my dermatology provider prior to any procedure and therefore; with my signature, agree to have any necessary procedures performed.

Patient Name:_____ Date:_____

Patient Signature:_____

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HIPAA CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.

The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.

- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone to confirm appointments? □YES □NO

May we leave a message on your answering machine at home or on your cell phone?□YES□NO

May we discuss your medical condition with any member of your family or friends?□YES□NO

If YES, please name the people allowed:

WITH THIS CONSENT, Sunshine State Dermatology and Skin Cancer Center Inc, MAY DISCUSS TREATMENT,PAYMENT OR HEALTHCARE OPERATIONS WITH THE FOLLOWING PERSON(S):

Patient Name and Relationship to Patient_____Phone:_____

Patient Name and Relationship to Patient_____Phone:_____

Patient Name:_____Date:_____

Patient Signature:_____

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RECEIPT OF NOTICE PRIVACY PRACTICES

Your privacy is important to us. The information that we record about you and your medical history is to help us provide quality medical care. We are committed to protecting this information. The Notice of Privacy Practice describes your rights with regards to your health information and our responsibility to protect that information. A complete copy of our Notice of Privacy Practices is available for you in our lobby.

Additional copies are available for you to take home.

Your Rights Include:

- The right to amend your health information.
- The right to request restrictions on what information we use or know we disclose your health information.
- The right to see an account of certain disclosures we have made of your health information.
- The right to obtain access to your health information with limited exceptions (written request, advance notice and a cost-based fee for expenses delineated by law)
- The right to receive a paper copy of our Notice of Privacy Practices

These rights do have certain restrictions and you may obtain detailed disclosure of these restrictions at any time. My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Personal Health Information.

*Copy provided upon request.

Patient Name:_____Date:_____

Patient Signature:_____