DERMATOLOGY
CONSULTANTS OF GLOUCESTER

Timothy Gardner, MD • Amanda Hullett, PA-C

# CONSENT FOR PROCEDURES

The undersigned authorizes Dermatology Consultants of Gloucester to perform dermatology (skin care) services on the patient named below, which may include cancer evaluation and the removal of any suspected cancer lesion, as more fully explained on the second page to this Consent for Procedures; and (ii) to bill the appropriate party (including Medicare and/or other insurance) for such services.
In addition, please review and sign the enclosed HIPAA Patient Consent Form.

**PATIENT NAME:**

**Date:**_____,_____**FACILITY NAME:** _____

**Authorization and Consent of Patient** (if patient is unable to provide consent, obtain authorized signature in section below)

PATIENT SIGNATURE: _____

WITNESS SIGNATURE: _____

**Authorization and Consent of Legal Guardian or Holder of Power of Attorney**

The individual signing on behalf of the patient hereby represents and certifies that he or she holds a valid power of attorney for the patient or is the patient's legal guardian and has the power and authority to execute this consent and authorization for treatment on behalf of the patient.

SIGNATURE: _____

PRINT NAME OF SIGNATORY: _____

WITNESS SIGNATURE: _____

DERMATOLOGY
CONSULTANTS OF GLOUCESTER

Timothy Gardner, MD • Amanda Hullett, PA-C

# CONSENT FOR PROCEDURES

(Continued)

1. My authorization signature on the preceding page hereby authorizes Dermatology Consultants of Gloucester to perform upon the named patient, medically necessary evaluation of suspicious skin abnormalities, possible biopsy and removal of precancerous and cancerous skin lesions. In addition, I understand and agree with all of the items listed below.
2. If any unforeseen conditions arise during the course of these procedure, I do hereby authorize Dermatology Consultants of Gloucester personnel to take whatever steps, and to perform whatever procedures they deem advisable which may be in addition to or different from those now planned.
3. I understand that there are always certain risks and consequences that are associated with the aforesaid procedures. These, among others, are scarring, pigmentary changes to the skin, reoccurrence of skin cancer or other lesion/problem, and possible damage to blood-vessels, or parts next to them, such as nerves, infection, or allergic reactions or other complications.
4. I acknowledge that no guarantee or assurance has been made to me as to any of the results or risks, and I assume such risk, and that the practice of medicine is not an exact science, and I understand these facts. I will ask if I want to have further explanation, discussion or description of the risks involved in these procedures.
5. I consent to the disposition by Dermatology Consultants of Gloucester of any tissue parts, which may be removed from named patient. I understand that this tissue will be sent for pathologic evaluation to a board-certified dermatopathologist and that named patient will be financially responsible for all the charges related to this evaluation regardless of the reimbursement from insurance carrier. I also understand that I will not hold Dermatology Consultants of Gloucester professionally or personally responsible for the pathologic interpretation of said tissue and that this tissue may be send for additional tests or evaluation at my or my insurance companies' expense.
6. FOR PATIENT UNDERGOING SKIN CANCER TREATMENT: I understand that I have skin cancer and that it is my responsibility to seek follow-up care by Dermatology Consultants of Gloucester personnel or other dermatology professionals in one (1) month then every three (3) month in the first year, every four (4) months the second year, every six (6) months the third, fourth and fifth years, and then yearly for the rest of my life. Failure to see follow-up care is my responsibility and I do not hold Dermatology Consultants of Gloucester professionally or personally responsible for skin cancer follow up.

6790 Wood Ridge Drive, Gloucester, VA 23061
PH (804) 693-6527 • FAX (804) 693-6615

DERMATOLOGY
CONSULTANTS OF GLOUCESTER

Timothy Gardner, MD • Amanda Hullett, PA-C

# HIPAA PATIENT CONSENT FORM

Dermatology Consultants of Gloucester's Notice of Privacy practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. This Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

## The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this consent.

This consent was signed by: _____

**Printed Name**

_____, _____

**Authorization Signature** **Date**

☐ Patient Signature ☐ Guardian or Power of Attorney

6790 Wood Ridge Drive, Gloucester, VA 23061
PH (804) 693-6527 • FAX (804) 693-6615