Academic DERMATOLOGY
Cutaneous Surgery & Laser Center

6545 France Ave South, Suite 564
Edina, Minnesota 55435

Patient Consent

TO OUR PATIENTS: before you begin treatment at Academic Dermatology, please read this form and indicate your consent by signing at the bottom. If you do not understand something on this form or do not wish to consent to all sections, please ask for help.

RELEASE OF HEALTH INFORMATION: I understand it is important for my medical provider to have access to my health information, which will help them safely treat me and manage my medical care. I consent to the release of my health information to any of the care providers involved in my current treatment, including referring providers. I consent to release of my health information for fraud investigation, quality of care review studies, and other health care operations purposes or to my insurance company, my family, or others as part of my health treatment.

ASSIGNMENT OF BENEFITS: I request that payment of authorized Medicare, Medicaid, insurance, or health plan benefits be made on my behalf to Academic Dermatology, and or my physician, for any services furnished to me by or in Academic Dermatology. I authorize any holder of medical or other information about me to release to such payer or their agents any information needed to determine these benefits or benefits for related services. I agree that my insurance can be billed for Workers Compensation visits that are determined not payable by Workers Compensation. I agree to pay for any charges not covered by any third party payer. I understand that medical insurance policies are an arrangement between an insurance carrier and me. I understand that charges for some services may be more that what some insurances companies choose to call "usual and customary" and that unless I am covered by and in compliance with a health plan with which Academic Dermatology has a participation agreement to provided covered services, I am personally responsible for all changes applied to my account. In the event that a minor patient is presented by someone other than the responsible party, the person who brought the minor will be accountable for charges incurred (except those covered by insurance). I understand that if I do not provide health insurance information Academic Dermatology will bill me directly.

RESPONSIBILITY FOR PERSONAL PROPERTY: I understand that Academic Dermatology and its staff are not responsible for the loss of valuables such as teeth, glasses, hearing aids, clothing, jewelry, watches, wheel chairs, prosthetic devices, etc.

BLOOD TESTING: I understand that under rare circumstances, others may be accidentally exposed to my blood or other body fluids while I am receiving care. If this occurs, I consent to the testing of my blood for the presence of blood borne pathogens (e.g. Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus). These tests are necessary to help protect and counsel the exposed individual. I understand that results of the tests will be part of my medical record and will not be released except with my prior consent or as required or permitted by law.

NOTICE OF PRIVACY PRACTICE: I acknowledge that Academic Dermatology's Notice of Privacy Practices has been made available to me, either in a brochure or by prominent posting in the reception area. I know that I can ask for a copy of the Notice at any time.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly; obtain payment from third party payers; conduct normal healthcare operations such as quality assessments and physician certifications. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

CONSENT TO TAKING PHOTOGRAPHS: I consent that photographs may be taken of me or parts of my body only with consent of the provider and under such conditions approved by the provider. The photographs shall be taken by my provider or by a photographer approved by my provider. The photographs shall be used for my medical records and medical care.

CONSENT TO THE PERFORMANCE OF MINOR DIAGNOSTIC AND THERAPEUTIC PROCEDURES: I consent to the performance of any required diagnostic procedures, including blood drawing, skin scrapings, shave and punch biopsies, and any required sutures. In addition, I consent to the performance of minor therapeutic procedures including incision and drainage of abscesses, laser and light treatments, and injections of medications and fillers.

I understand I have the right to revoke this consent, in writing, at any time except where Academic Dermatology or its practitioners have already relied on this consent.

Patient Signature _____ Date _____