Colorado Dermatology Institute

NCQA Patient-Centered Specialty Practice Recognized

INFORMED CONSENT SIGNATURE PAGE ***Revised May 2016***

Dermatology care often requires procedures and consents to diagnose and treat conditions and to perform other functions. In addition, Colorado Dermatology Institute (CDI) has established policies to provide the best possible patient care. Finally, the government has established regulations for patient privacy (HIPAA) and Identify Theft Protection that we follow for the safety of all our patients.

It is important that these procedures, policies, consents and regulations are understood by each patient and/or their designated legal guardian and that the patient/designated legal guardian gives their consent to procedures and certain practices being performed, their agreement to follow CDI policies, and their understanding of regulations.

Please initial by each policy, consent, and regulations below, indicating you have read, understand, and agree to comply to each one.

_____ 1. Financial and Missed Appointments Policy and Procedures - revised May 2016.

_____ 2. Surgical Procedures Informed Consent - revised May 2016.

_____ 3. Consent to Have Medical Students and Residents in Exam Room - revised May 2016.
Agree _____ Do Not Agree _____

_____ 4. Consent to the Taking of Photographs - revised May 2016.

_____ 5. Consent to CDI Mailing Out Appointment Reminder Cards - revised May 2016.

_____ 6. Consent to Leave Details of Biopsy Results on My Telephone Voicemail – revised May 2016. Voicemail number:_____________________Agree: _____ Do Not Agree: _____

_____ 7. Consent to contact me via unencrypted email for appointments, for access to the Patient Portal to view my Medical Record, to receive biopsy results, to send my Medical Record to another Provider/Medical Establishment upon my request, or for insurance/financial matters.
My email address is (please print)____
Agree _____ Do Not Agree _____

_____ 8. Patient Privacy and Protected Health Information Regulation - revised May 2016.
I have read the Colorado Dermatology Institute's Notice of Privacy Practices (HIPAA).
I understand that upon request, I will be given a copy of these Privacy Practices.

_____ 9. Identity Theft Prevention and Detection and Red Flag Rule Compliance Regulation - revised May 2016.

With your signature, you verify that you have read, understand, and agree to comply with the above policies, consents, and regulations which are available for viewing in this Patient Registration package.

Primary Insured SSN:________________________________

Patient's SSN (Last 4 Numbers):______________________

Patient Name (Please Print): ____DOB: _________

Parent/Legal Representative Name (Please Print): ____

Signature of Patient/Parent/Legal Representative: _______________________________________

Relation to Patient: ____ Date: __________

<u>Parents/Legal Guardians with Minors Needing Dermatologic Treatment: Please go to Page 2 on the reverse side</u>

10. Consent for Treatment of a Minor form dated May 2016:

I am the parent or legal guardian of (patient's name) ______________________________________.
I authorize and give consent to the Colorado Dermatology Institute for medical evaluation and treatment of my child/charge if a parent/legal guardian or other specifically authorized adult is not present. I have read and completed the full Consent located in this Patient Registration package.

Condition we are authorized to treat:____

____

Parent/Guardian (Print):____

Signature of Parent/Guardian: ____DOB: ___________

Relationship to Patient: ____

Names and relationship to the minor of other adults who are authorized to escort the minor:

____

____

____

O: 719.531.5400 | F: 719.531.9545 www.CoDerm.com