DR. FAZELI & DR. BROUMAND

DERMATOLOGY

Patient Name_____ **Date of Birth**_____

CONSENT

I give my consent for Dermatology Associates to discuss my medical care and payment for medical care with the following people:

_____ _____

Name/relationship/phone number Name/relationship/phone number

PATIENTS READ AND SIGN AGREEMENT

1- I hereby give consent for the providers of Dermatology Associates of CNY to evaluate and treat the above patient.
2- I'm aware that the **Privacy Practices Notice** is available at my request.
3- I understand that my personal health information will be used for the purpose of treatment, payment and coordination of health care needs of the patient.
4- I also have been provided and agree with the **Financial Policy** of Dermatology Associates of CNY.

_____ _____ _____

Responsible Party Signature Relationship Date

I reviewed my personal and insurance information and updated any changes from my last office visit.

Initial_____ Date_____ Initial_____ Date_____

Initial_____ Date_____ Initial_____ Date_____

Initial_____ Date_____ Initial_____ Date_____