This Consent for Treatment provides Findley Dermatology LLC with your permission to perform reasonable and necessary medical examinations, testing and treatment.

Health Care Services

I understand that, by signing this Consent for Treatment, I give my consent to receive professional health care services, either in-person or via Telehealth (defined below), as appropriate. Professional care may include, but is not limited to, review of any information I have provided or questions I have answered prior to an examination, an examination and/or consultation, surgical procedures, prescription of medication, and provision of any follow-up treatment, as needed.

"Telehealth" is the delivery of health care services using technology when the health care provider and patient are not in the same physical location, or the virtual delivery of health care services, including by a medical provider or via digital or automated tools, including without limitation tools for medical or health-related diagnosis and treatment. Telehealth may be used for diagnosis, treatment, follow-up or patient education, and may include, without limitation, the following: electronic transmission of patient medical records, medical images, or other patient data; synchronous (i.e., "real time") and asynchronous (i.e., non-"real time") interactions via audio, video or data communications; automated or digital tools for diagnosis, care, treatment or communication pertaining to health care or medical matters; and output data from medical devices, sound and video files. I agree that if my health or medical problem or condition persists after my use of Telehealth, I will immediately contact a medical services provider and seek appropriate additional in-person medical care or emergency care, as appropriate. I understand that while using Telehealth services offers potential benefits, there are potential risks. I acknowledge these risks and consent to the use of automated tools for diagnosis, treatment, care, or other communication pertaining to health care matters.

I understand that there are risks and benefits when receiving health care services generally. I understand that when I receive care, the risks and benefits of such care will be explained to me, and I will have the opportunity to ask my health care providers questions about such risks and benefits. I acknowledge that no guarantees have been made to me regarding the result of a diagnosis or treatment

I authorize the Findley Dermatology LLC to share information pertaining to health care services I receive with other individuals for treatment, payment and health care operations purposes. I also authorize Findley Dermatology LLC to obtain my health information from my referring treatment provider if such information is necessary for my treatment.

Payment

I agree that I am financially responsible for and agree to pay Findley Dermatology LLC for the provision of medical care. If I choose to have my health insurance reimburse Findley Dermatology LLC for my care, I agree that Findley Dermatology LLC may bill any such insurer. I understand that my insurance may not pay for all the services that I receive and that I am responsible for paying for services denied by my insurer. I assign to Findley Dermatology LLC the right to receive payment from my health insurer.

For self-pay patients without insurance, non-participating insurances and out-of-network insurances, payment is due for services at the time of the visit.

In the event any unpaid balance is placed under collections by a third-party collector, any collection fees will be added to the unpaid total amount due to Findley Dermatology LLC.

Electronic Correspondence and Voicemails

I consent to receive emails, text messages or other communications, including automated or prerecorded messages from Findley Dermatology LLC pertaining to my care and my health (such as automated reminders). By replying to emails, I acknowledge that I am aware that email is not a secure method of communication, and that I agree to the risks. I also authorize Findley Dermatology LLC to leave voicemail messages on the telephone number(s) that I provide to Findley Dermatology LLC. I understand that I can email info@findleyderm.com and ask to not be contacted via phone or email.

Individuals Involved in my Care or Payment for my Care

Findley Dermatology LLC may share information about my care to the following individuals, who are involved in either my care or the payment for my care:

Name: ______________________________ Relationship: ________________ Phone: ________________

Name: ______________________________ Relationship: ________________ Phone: ________________

Name: ______________________________ Relationship: ________________ Phone: ________________

Treatment of a Minor

_______________________________________ is under the age of 18 years, and I give permission for them to be evaluated/treated in my absence.

Cancellation/No-Show Policy

We understand that situations arise necessitating moving an appointment time and/or date. However, in the absence of giving a 24-hour notice for canceling or rescheduling an appointment, a $50 fee will be charged. If you no-show for more than 2 scheduled visits, you may be discharged from care at the office.

Acknowledgements

By executing this Consent for Treatment, I acknowledge that I am voluntarily seeking health care and consent to receive treatment from Findley Dermatology LLC. I acknowledge that I am at least 18 years of age, an emancipated minor, or the parent/legal guardian of a minor under 18 years of age. The permissions granted herein shall begin on the date of signature and shall remain effective until I terminate this Consent for Treatment. I understand that I have the right to withhold or withdraw my consent at any time by submitting a request to Dr. Alyssa Findley at info@findleyderm.com. I acknowledge that I have had the opportunity to have any questions addressed to my satisfaction. I have read this Consent for Treatment and agree to the provisions contained above.

____

Signature

Name: ____

Date: ____

If legal representative:

Patient Name: ____

Relationship to Patient: ____