CONSENT FOR PROCEDURES

_____("Patient") authorizes OnSite Dermatology of Connecticut, LLC (together with its personnel, "OnSite") (i) to perform dermatology (skin care) services on Patient named below, which may include medically necessary evaluation of suspicious skin abnormalities including cancer, possible biopsy and removal of suspected cancerous, precancerous and cancerous skin lesions (collectively, the "Services"), as more fully explained below; and (ii) to bill the appropriate party (including Medicare and/or other insurance) for such services. Patient acknowledges that OnSite is not affiliated with Patient's resident community/facility, and such community/facility is not responsible for the Services performed by OnSite. Patient authorizes OnSite to perform the Services. In addition, Patient understands and agrees to each of the following items:

1. If any unforeseen conditions arise during the performance of the Services, OnSite is authorized to perform all necessary and advisable steps and procedures in addition to or different from the Services.

2. There are certain risks and consequences that are associated with the Services. Among these are scarring, pigmentary changes, reoccurrence of skin cancer or other lesion/problems, possible damage to adjacent blood-vessels and nerves, infection, allergic reactions and/or other complications.

3. I acknowledge that the practice of medicine is not an exact science and that no guarantee or assurance has been made to me regarding results or risks and I assume such risk. I understand these facts. I will ask if I want to have further explanation, discussion or description of the risks involved with the Services.

4. I consent to the disposition by OnSite of any tissue which may be removed from Patient. I understand that this tissue will be sent for pathologic evaluation to a board-certified dermatopathologist and that Patient will be financially responsible for all charges related to this evaluation regardless of any insurance reimbursement. I will not hold OnSite responsible for the pathologic interpretation of such tissue and I understand that the tissue may be sent for additional tests or evaluation at my or my insurance companies' expense.

5. **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 OnSite or other dermatology professionals in one (1) month and thereafter every three (3) months 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. *Follow-up care is my responsibility and I do not hold OnSite responsible for my skin cancer follow up or my failure to seek it.*

COMMUNITY/ FACILITY NAME: _____

This consent was signed by: _____
(Print Name)

Authorization Signature **Date**

☐ Patient Signature ☐ Guardian or Power of Attorney for Patient*

Tel: 877-345-5300 Fax: 561-989-3665
www.onsitederm.com

HIPAA PATIENT CONSENT FORM

OnSite's notice of privacy practices ("Notice") provides information about how OnSite may use and disclose protected health information about Patient. The Notice contains a Patient Rights section describing Patient's rights under the law. You have the right to review OnSite's Notice before signing this consent. The terms of OnSite's Notice may change. If OnSite changes its Notice, Patient may obtain a revised copy by contacting office.

You have the right to request that OnSite restrict how protected health information about Patient is used or disclosed for treatment, payment, or health care operations. OnSite is not required to agree to such restriction (s), but if it does, OnSite shall honor that agreement.

By signing this form, Patient consents to OnSite's use and disclosure of protected health information about Patient for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by Patient. However, such a revocation shall not affect any disclosures OnSite have already made in reliance on Patient's 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
- OnSite has a Notice of Privacy Practices and Patient has the opportunity to review this Notice
- OnSite reserves the right to change the Notice of Privacy Practices
- Patient has the right to restrict the uses of Patient information, but OnSite is not required to agree to those restrictions
- Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- OnSite may condition receipt of treatment upon the execution of this consent.

This consent was signed by: _____

(Print Name)

_____

Authorization Signature **Date**

☐ Patient Signature ☐ Guardian or Power of Attorney for Patient*

*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.

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