hdg
Hecker Dermatology Group
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Pompano Beach, FL 33064
(954) 783-2323 Fax (954) 783-2321
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CONSENT FOR TREATMENTINSURANCE RELEASE/AUTHORIZATION

Please sign and/or place your initials in the spaces below

I give my permission for the doctors and staff of *Hecker Dermatology Group, P.A.* to treat me, including any biopsy procedure(s), as deemed necessary in the exercise of their professional judgment. I will discuss any procedure(s) with the doctors and staff first and ask any questions I may have concerning these procedure(s).

_____ I understand that medical care requires my cooperation, and I will follow my doctor's orders and prescriptions. If indicated, I will make and keep appointments for follow-up care and call the office to note any changes or concerns in my condition.

_____ I authorize my physician and *Hecker Dermatology Group, P.A.* to take photographs/video tape or by other similar means record my surgery/procedure(s). I understand that reproduction or publication of said photographs and recordings will be used for the purpose of medical/scientific/diagnostic study and research, education, before and after surgical portfolios and/or documentation for my medical record.

_____ I understand that the photographs and recorded material may include appropriate portions of the body to demonstrate surgery/procedure(s) and that every effort will be made to protect the patient's identity in those materials.

_____ I further acknowledge that all recorded media obtained is the sole property of *Hecker Dermatology Group, P.A.*

_____ I hereby certify that I have read the foregoing CONSENT and fully understand the contents thereof.

Patient Name (Print)_____Date_____

Patient Signature (or Parent if Minor)_____

Witness_____Date_____

AUTHORIZATION AND RELEASE

_____ I have read and understand the medical consent forms that have been provided to me by the doctors and staff of *Hecker Dermatology Group, P.A.*

_____ I authorize my doctor to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical care to third party payers, including Medicare.

_____ I authorize and request that my insurance company, in lieu of reimbursing me directly, pay to the doctor or the medical group any benefits for services rendered.

_____ I understand that my medical insurance carrier may pay less than the actual bill for services. I agree that I may be responsible for payment of all services rendered on my behalf or my dependents.

_____ I understand I may be billed by an outside laboratory for work that is performed in this office, if my insurance company does not have a contracted lab or facility, or if services are not covered by my insurance company.

_____
Signature of Patient or Parent (if Minor)