Florida Medical Clinic Dermatology
Your life. Our specialty.

Rachel E. Careccia, MD, FAAD
Board Certified Dermatologist
Board Certified Dermatopathologist

Jamie Johnson, MSN, ARNP-C

12500 N. Dale Mabry Hwy, Carrollwood, FL. 33618
(P) 813.712.5702 (F) 813.377.1005

OFFICE POLICY

- We see patients ages 24 months and older. Any patient under the age of 18 must be accompanied by a parent or legal guardian at each visit.
- Please assist us by showing up on time so that we may accommodate everyone in a timely manner. This is especially important if you are scheduled to undergo a surgery or other procedure. If you arrive significantly later than your scheduled appointment time we may need to reschedule, although we will make every attempt to ensure that you are seen in a timely manner. If you arrive too late for your appointment or do not show for your appointment, we may, at our discretion, assign a $25 out-of-pocket fee. This fee needs to be paid prior to scheduling your next appointment. As surgical or procedural appointments are lengthy and sometimes scheduled months in advance, a fee of up to $75 may be assessed if you do not show for these appointments. We typically make several attempts to remind you of these appointments.
- Although our goal is to stay on time, many factors influence our ability to adhere to the schedule. Please assist us in our efforts to provide the best care for all of our patients by limiting the number of issues that you would like addressed at each visit. As an example, acute or new onset rashes require time and expertise to diagnose and treat, so scheduling a full skin screening during the same visit may not be possible. A complete and thorough skin examination deserves its own visit. Attempting to address multiple different issues during one visit often leads to inadequate counseling, time delays and patient dissatisfaction.
- We offer cosmetic services such as Botox and dermal fillers and chemical peels. During routine medical dermatology visits, it is often difficult to address all of your cosmetic options during the time allotted. We offer a separate cosmetic consultation, so that all of your concerns can be carefully considered and addressed.
- Existing patients may leave a message with the nursing staff for medical questions, prescription refills and laboratory results. As we are very busy seeing patients during the work day, our staff will return your call as soon as possible, although it may not be until after the clinic has closed. We appreciate your patience.
- Patients are responsible for their co-payments and deductibles at the time of service. Payments may be made with cash, check or credit card.
- Insurance companies do not pay for cosmetic services. They do not pay for removal of benign lesions (skin tags, moles or warty growths) even if they are irritated. If coverage is a question, you will be asked to sign a waiver indicating your financial responsibility in the event of non-payment by your insurance policy.
- If a biopsy or surgery is performed, the tissue is sent to the laboratory facility to processing and interpretation. You and/or your insurance company may receive a separate bill for these services.
- We make every effort to obtain payment from your insurance company. If you have questions about your bill, please contact our billing department at (813) 528-4975. Unpaid balances that are over 60 past due are subject to referral to a collection agency. Please be aware that once your account has been turned over to collections, you will incur a 30% surcharge on your balance.
- All returned checks are subject to a $25.00 charge.

Our mission is to provide you with the highest quality medical experience in a friendly, comfortable atmosphere. The current medical environment has created special challenges for both the recipients and providers of care. Please know that we are working diligently on your behalf, and we welcome constructive feedback on our services. Thank you for your support

_____ _____

PRINTED NAME SIGNATURE

AMERICAN ACADEMY OF DERMATOLOGY AAD 1938

Excellence In Dermatology™

F E L L O W

Florida Medical Clinic
Your Life, Our Specialty

PATIENT INFORMATION

FIRST NAME _____ MIDDLE _____ LAST NAME _____

LOCAL ADDRESS _____ DATE OF BIRTH ____/____/____ SEX _____

CITY _____ STATE _____ ZIP _____ EMAIL ADDRESS _____

SOCIAL SECURITY _____ CELL PHONE ( ) _____

ETHNICITY: ☐ NOT HISPANIC/LATINO ☐ HISPANIC/LATINO ☐ REFUSED HOME PHONE ( ) _____

RACE: ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ ASIAN ☐ WHITE WORK PHONE ( ) _____

☐ BLACK/AFRICAN AMERICAN ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER REFERRING PHYSICIAN _____

☐ OTHER ☐ OTHER SPECIFIED _____ PRIMARY PHYSICIAN _____

PREFERRED LANGUAGE _____ PHONE ( ) _____

☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED EMPLOYER _____

☐ EMPLOYED ☐ RETIRED ☐ FULL TIME STUDENT ADDRESS _____

PERMANENT ADDRESS

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT

NAME _____ HOME PHONE ( ) _____

RELATIONSHIP _____ WORK PHONE ( ) _____

IS THE PATIENT THE FINANCIALLY RESPONSIBLE PARTY? ☐ YES ☐ NO IF NO PLEASE COMPLETE THIS SECTION

RELATIONSHIP _____ SEX _____ DAYTIME PHONE ( ) _____

FIRST NAME _____ MIDDLE _____ EMPLOYER _____

LAST NAME _____ ADDRESS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CITY _____ STATE _____ ZIP _____

IS THE REASON FOR YOUR VISIT THE RESULT OF AN ACCIDENT? ☐ YES ☐ NO IF YES PLEASE COMPLETE THIS SECTION

NOTE: NOT ALL FMC OFFICES ACCEPT AUTO OR WORKMAN COMPENSATION PATIENTS.

PLEASE CHECK WHICH TYPE OF ACCIDENT: ☐ WORKMAN COMPENSATION ☐ AUTOMOBILE ☐ OTHER

DATE OF ACCIDENT ____/____/____ Place of accident _____ How did accident happen? _____

CLAIM # _____ CLAIM REPRESENTATIVE/ADJUSTER _____

IF WORKMAN COMPENSATION PLEASE COMPLETE THIS SECTION

EMPLOYER NAME _____ EMPLOYER PHONE( ) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURANCE COMPANY _____ INSURED'S DOB _____

INSURANCE/CARD HOLDER'S NAME _____ RELATIONSHIP _____

ID# _____ GROUP # _____ PHONE ( ) _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY _____

INSURANCE/CARD HOLDER'S NAME _____ RELATIONSHIP _____

ID# _____ GROUP # _____ PHONE ( ) _____

SIGNATURE _____ DATE _____

FLORIDA MEDICAL CLINIC, P.A.

Your Life, Our Specialty

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Florida Medical Clinic, P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to the conduct health care operations of Florida Medical Clinic, P.A. I understand that diagnosis or treatment of me by Florida Medical Clinic, P.A. may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Florida Medical Clinic, P.A. *Notice of Privacy Practices* prior to signing this document. The Florida Medical Clinic, P.A. *Notice of Privacy Practices* has been provided to me. The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Florida Medical Clinic, P.A. The *Notice of Privacy Practices* for Florida Medical Clinic, P.A. is also provided at 38135 Market Square, Zephyrhills, FL 33542. This *Notice of Privacy Practices* also describes my rights and the duties of Florida Medical Clinic, P.A. with respect to my protected health information. Florida Medical Clinic, P.A. reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices.*

Lifetime Authorization: By signing below I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent or this physician or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or to the party who accepts assignment. The original authorization will be kept on file by Florida Medical Clinic, P.A.

I may obtain a revised *Notice of Privacy Practices* by requesting in writing from Florida Medical Clinic, P.A. or asking for one at the time of my next appointment.

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Florida Medical Clinic, P.A. (FMC) and or its affiliated entities for any charges not covered by healthcare benefits. It is my responsibility to notify FMC of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by FMC and/or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Florida Medical Clinic, P.A. (FMC) for all covered medical services and supplies provided to me during all courses of treatment and care provided by FMC and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with FMC, which will authorize and allow for direct payment to FMC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by FMC.

Initials _____

Ownership Disclosure

I understand that Florida Medical Clinic, P.A. is a physician-owned medical practice comprised of the offices of primary care physicians, specialty care physicians and associated ancillary services. These ancillary services include laboratory, pathology, radiology/diagnostic, physical therapy, pharmacy and ambulatory surgery center services. During the course of my care, I may be referred to one or more of these ancillary departments. I have the right to choose where to receive these services. I understand I am not obligated to receive these services at a Florida Medical Clinic ancillary department.

Acknowledgement of Receipt
Notice of Privacy Practices

I acknowledge that I have received a copy of Florida Medical Clinic's Notice of Privacy Practices, which describes how FMC will use and protect my health information. This Notice describes my rights under the Health Insurance Portability and Accountability Act (HIPPA) and FMC's policies on use and disclosure of my protected health information.

_____ _____
Name of Patient Name of Guardian or Personal Representative

_____ _____
Signature of Patient Signature of Guardian or Personal Representative

_____ Florida Medical Clinic, P.A.
Date Zephyrhills, FL 33542

cg / FMC Consent for Treatment, Payment & Health Care Operations

FLORIDA MEDICAL CLINIC, P.A.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact our Privacy Officer at 352-567-0188.

Florida Medical Clinic understands your privacy is important. This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition or payment.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains personal demographic information, your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment;
- Means of communication among the many health professionals who contribute to your care;
- Legal document describing the care you received;
- Means by which you or a third party payer can verify that services billed were actually provided;
- A tool in educating health professionals;
- A source of data for medical research;
- A source of information for public health officials charged with improving the health of the nation;
- A source of data for facility planning and marketing; and
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy;
- Better understand who, what, when, where and why others may access your health information;

- Make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522. However, we are not required to agree to the restriction;
- Inspect and copy your health record as provided for in 45 CFR 164.524 and Florida law. Usually this includes medical and billing records, but does not include psychotherapy notes. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
- Amend your health record as provided in 45 CFR 164.526. To request an amendment, your request must be in writing and must provide a reason that supports your request. We may deny your request if you ask to amend information that:
    - Was not created by us;
    - Is not part of the medical information kept by FMC;
    - Is not part of the information which you would be permitted to inspect or copy; or
    - Is accurate or complete.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528. To request this list or accounting of disclosures, your request must be in writing and must state the time period which may not be longer than six years and may not include dates before April 13, 2003. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list.
- Request communications of your health information by alternative means or at alternative locations;
- Receive confidential communications of protected health information as provided in 45 CFR 164.522 (b), as applicable;
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Copies of the regulations cited above may be requested from the Privacy Officer by calling 352-567-0188.

Our Responsibilities:

Florida Medical Clinic is required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction;

- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change significantly, we will post the new notice in each FMC location as well as on our Web site: www.floridamedicalclinic.com. You can also request a copy of our notice at any time.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact FMC's Privacy Officer at (352) 567-0188.

If you believe your privacy rights have been violated, you can file a complaint by contacting FMC's Privacy Officer at 352-567-0188 or you may send a written complaint to the Secretary, U.S. Department of Health and Human Services. FMC's Privacy Officer can provide you with the appropriate address upon request. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Care Operations

We will use your health information for treatment. For example, information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Different departments within Florida Medical Clinic may share medical information about you in order to coordinate different services you need, such as prescriptions, lab work and X-rays. We may also disclose medical information about you to people outside FMC who may be involved in your medical care, such as hospitals, long-term care facilities, ambulatory surgery centers or home health agencies.

We will also provide a referring physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you.

We will use your health information for payment. For example, a bill may be sent to you or an insurance company (third party payer). The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

We will use your health information for regular healthcare operations. For example, in day-to-day business practices, trained staff may handle your physical medical record in order to have the record

assembled or for filing reports into your record. Certain data elements are entered into our

computer system that processes most billing, schedules your appointments and for statistical reporting. As part of our improvement efforts to provide the most effective services, your record may be reviewed by professional staff to assure accuracy, completeness and organization.

This information may be shared by facsimile transmission.

Other Uses or Disclosures

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include our using an outside transcription service to type physicians' dictated notes or a copy service we may use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. So that your health information is protected, however, we require the business associate to agree in writing to appropriately safeguard your information.

Communication with Family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Coroners, Medical Examiners and Funeral Directors: We may disclose health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations: If you are an organ donor, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law. These programs provide benefits for work-related injuries or illness.

Public Health: As required by law, we may disclose your health information to public health or legal

authorities for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births or deaths;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure when you agree or when required or authorized by law.

Correctional Institution: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose to the institution or agents thereof, health information necessary for your health, and the health and safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law:

- In response to a court order, valid subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Clinic; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Other Uses and Disclosures of Your Information by Authorization Only

When you request information to be disclosed to another party or yourself, we will respond according to federal and state law.

We are required to get your authorization to use or disclose your protected health information for any use other than treatment, payment or health care operations, and those specific circumstances outlined above. We use an Authorization to Use/Disclose form that specifically states what information will be given to whom, for what purpose, and is signed by you or your legal representative. You have the ability to revoke the signed authorization at any time by a written statement given to us to that effect.

This Notice of Privacy Practices is effective April 14, 2003.

Name:

Rachel E. Careccia, MD, FAAD
Jamie Johnson, ARNP
813-712-5702

Dermatology

Florida Medical Clinic
Your life. Our specialty.

Name: _____ **Date of Birth:** _____/_____/_____
(Last, First, Middle Initial)

Primary Physician: _____ **Pharmacy of Choice:** _____

What is the reason for your visit today?

Concerns:	**Location:**	**Duration:**	**Prior Treatments:**
1.			
2.			
3.			

Past Medical History:
Do you have a history of the following?

Adhesive tape allergy	Yes	No
Latex allergy	Yes	No
Local anesthetics allergy	Yes	No
Epinephrine sensitivity	Yes	No
Bacitracin allergy	Yes	No
Neosporin allergy	Yes	No
Anticoagulants / Taking blood thinners	Yes	No
Bleeding disorders	Yes	No
Artificial joint	Yes	No
Artificial heart valves	Yes	No
Congenital heart defect	Yes	No
Pacemaker/defibrillator	Yes	No
Mitral valve prolapse	Yes	No
Immunosuppressed	Yes	No
Organ Transplant	Yes	No
CLL Chronic leukemia	Yes	No
Pre-Op/Pre-dental antibiotics	Yes	No
Memory problems	Yes	No
Fainting / syncope	Yes	No
Hepatitis	Yes	No
HIV positive	Yes	No
MRSA	Yes	No

Eczema	Yes	No
Asthma	Yes	No
Hay fever	Yes	No
Heart disease	Yes	No
Diabetes	Yes	No
Kidney disease	Yes	No
Thyroid disease	Yes	No
Lupus	Yes	No
Arthritis	Yes	No
Psoriasis	Yes	No
Cancer (internal)	Yes	No
Blood clots	Yes	No

If yes to the above, please elaborate below:

Do you have a history of melanoma? Yes No
Do you have a history of other skin cancer(s)? Yes No
Details:

_____

Current Medications, including over-the-counter _____ If none, check here
Please list medications below:

_____
_____
_____

Allergies to Medications (list medications and type of reaction):

_____
_____

Name:

Surgical History:

_____

_____

_____

Family History

Do you have a family history of melanoma? Yes No

Do you have a family history of other skin cancer(s)? Yes No

Type(s): _____

Do you have a family history of atopic dermatitis/eczema? Yes No

Do you have a family history of psoriasis? Yes No

Social History:

Occupation: _____

Hobbies: _____

Do you use Tobacco?	No	Yes	Previous	Type: _____	
Alcohol Consumption:	None		Socially	Moderate	Daily
Do you use sunscreen?	None		Daily	Occasionally	
Tanning bed use?	None		Current	Previous	

Do you have any other medical problems/conditions that are not listed and that we should be aware of?

_____

_____

_____

Do you currently have or recently have had any of the following symptoms?

Fever/Chills	Yes	No
Nausea/vomiting	Yes	No
Unexplained Weight loss	Yes	No
Swollen lymph nodes	Yes	No
Blood in stool/urine	Yes	No
Swollen/hot joints	Yes	No
New/changing moles	Yes	No
Dry/sensitive skin	Yes	No
History keloids/thick scars	Yes	No
History cold sores/HSV	Yes	No

FOR WOMEN ONLY

Are you pregnant?	Yes	No	Due date: _____
Are you breastfeeding?	Yes	No	
Are you on birth control?	Yes	No	If yes, type/name: _____

SIGNATURE OF PATIENT _____ Today's Date: _____

SIGNATURE OF PROVIDER _____

Florida Medical Clinic, P.A.
Authorization to Share Protected Health Information

Patient Name:	Second Form of Identification (DOB/Account#)

I authorize the physicians and staff of:

- ☐ All FMC Departments
- ☐ The following FMC Departments

Specify:

_____

_____

_____

to share protected health information with the following persons:

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

This includes (please check all areas that apply)

- ☐ All Medical Information
- ☐ Lab Results
- ☐ X-ray Results
- ☐ Medication (RX Renewal and Pickup)
- ☐ Telephone Consults
- ☐ Hospital Information
- ☐ Insurance Information
- ☐ Dialysis Clinic Information
- ☐ Appointment Information
- ☐ Other (please specify)

This authorization will be in effect until authorization is revoked.

Patient's Signature_____ Date_____

Witness _____

Florida Medical Clinic Dermatology
Your life. Our specialty.

Rachel E. Careccia, MD, FAAD

Board Certified Dermatologist
Board Certified Dermatopathologist

12500 N. Dale Mabry Hwy, Carrollwood, FL. 33618
2100 Via Bella Boulevard, Land O Lakes, FL. 34639
(P) 813.712.5702 (F) 813.377.1005

Consent to Taking Photographs

In connection with the medical services which I am receiving from my physician, Rachel Careccia, M.D. and her associates, I consent that photographs may be taken of me or parts of my body, during and after treatment.

- The photographs shall be used for my medical records.
- The photographs may be used to coordinate care between my health care providers, especially as it relates to additional medical procedures that may be necessary in the course of my care.
- The photographs may be taken only with the consent of my medical provider, and under such circumstances and at such time as approved by my provider.
- The photographs shall only be taken by my provider or by a staff member approved by my provider.
- The photographs may be provided to my insurance company at my request or if requested by my insurance company.
- Photographs may be used by my provider for educational purposes. It is specifically understood that I shall not be identified by name and when possible, my face and/or identifying characteristics will not be shown.

Printed Patient Name _____ Date: _____

Patient Signature _____