



Damon McClain, MD, FAAD Susannah Berke, MD, FAAD Molly McIntyre, PA-C, MMS, MPH Leah Greco, PA-C

Consent to Treat

Patient Name: _____ **Date of Birth:** _____

I, the undersigned, voluntarily consent to evaluation, examination, and treatment by the healthcare providers and staff of **Three Rivers Dermatology**. I understand that:

1. Routine Medical Care

- The healthcare providers may perform examinations, diagnostic testing, and minor procedures as deemed medically necessary during routine care, including but not limited to shave biopsies or similar procedures when there is clinical suspicion for malignancy or other pathological abnormalities.
- I understand that I have the right to ask questions about my treatment and may refuse any procedure or treatment at any time.

2. Risks and Benefits

- While every effort will be made to minimize risks, I understand that all medical procedures carry some degree of risk. The specific risks, benefits, and alternatives will be explained and discussed with me prior to or at the time any procedure is performed.

3. Consent for Minors

- If the patient is under 18 years of age, I am the parent or legal guardian and have the authority to provide consent for treatment.

4. Privacy & HIPAA**

- I acknowledge that I have received and reviewed the **Notice of Privacy Practices and HIPAA** explaining how my health information may be used and disclosed.

5. Billing & Financial Responsibility**

- I authorize Three Rivers Dermatology to release my medical information to my insurance company for services rendered and assign all insurance benefits to the practice. I understand that I am financially responsible for any charges not covered by my insurance, including all costs if the practice is out-of-network, and that I will not submit any related claims to my insurers.

Notice: The **Privacy and HIPAA** disclosures have been provided to you via text/email at the time your appointment was scheduled. A physical copy of any **Three Rivers Dermatology** policies referenced in or related to this consent are available to patients upon request.

Patient/Guardian Signature: _____ **Date:** _____

Provider/Staff Witness: _____ **Date:** _____