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**Patient Information**

(Please Print)

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle

Birthdate: \_\_\_ /\_\_\_ /\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: ⁭Male ⁭Female

Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: ⁭ Single ⁭ Married ⁭ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street & Apt # City State Zip

Home Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

Cell: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **May we send communications by text?**   YES  NO

**Where do you prefer to be contacted?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **May we leave a message?**   YES  NO

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **May we send communications by e-mail?**   YES  NO

**Employment Information**

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext. \_\_\_\_\_\_\_\_\_\_ **May we leave a message?**   YES  NO

**If Under the Age of 18**

Name of Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may authorize treatment for the minor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ Cell: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street & Apt # City State Zip

**How did you hear about Dr. Coley?**

 Family/Friend: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Seminar/Event

 Billboard  Internet (website, Google)  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I understand that office visit charges are payable on the day service is rendered. I authorize Coley Cosmetic and Hand Surgery Center to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Coley Cosmetic and Hand Surgery Center and myself.*

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| ***Cosmetic Interest Questionnaire*** |

|  |  |  |  |
| --- | --- | --- | --- |
| Your Name: |  | Today’s Date: |  |

|  |  |
| --- | --- |
| ***How did you hear about us?*** | |
| * Friend or Family Member (Please List) |  |
| * Physician or other healthcare provider |  |
| * Internet: ⁭ Coley Cosmetic Website ⁭ Practice Dock ⁭ Locate A Doc ⁭ Google ⁭ Perfect Yourself |  |
| * Seminar or other event (date & location) |  |
| * Other |  |
| * Billboard |  |

|  |
| --- |
| ***What brings you to the office today?*** |
|  |
| ***Would you like to see our Aesthetician for a complimentary skin consultation today?*** |
| YES NO |

|  |  |  |
| --- | --- | --- |
| ***What are your areas of concern?*** |  | |
| *(Please check all that apply)* |  | |
| *FACE* | *BREASTS* | *BODY* |
| Frown lines between the brows | Size | Abdomen |
| Skin Quality | Shape | Legs |
| Hyperpigmentation | Symmetry | Arms |
| Loose skin |  | Hips |
| Neck – Double chin |  | Back |
| Ears |  | Female Rejuvenation |
| Eyelids or Brows |  |  |
| Nose Shape |  |  |
| Lips |  |  |
|  |  |  |

Hormone Replacement Therapy

Thermi Smooth/VA/Tight non-invasive skin tightening

|  |
| --- |
| ***Are you interested in learning more about the following?*** |
| *(Please check all that apply)* |
| Botox or Dysport |
| Injectable Fillers: Juvederm, Radiesse, Sculptra, Restylane |
| Chemical Peels |
| Skin Care Products |
| Facial Cosmetic Surgery (Eyes, Brows, Nose, Chin, Face Lift) |
| Liposuction |
| Tummy Tuck |
| Breast Surgery |
| Laser Hair Removal |
| Body Contouring/CoolSculpting  Tattoo Removal |

**MEDICAL HISTORY**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_ Height\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_

Reason for Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY: (Circle all that apply. Please provide a brief explanation to any “YES” answers)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Ear/Eye (dryness)/Sinus problems/nose bleeds | YES | NO | Liver problems/Hepatitis | YES | NO |
| Heart Disease/Surgery | YES | NO | GI problems (ulcer/reflux/abdominal pain) | YES | NO |
| High or Low Blood Pressure | YES | NO | Genitourinary Problems (UTI/kidney or bladder issues) | YES | NO |
| CAD/chest pain/palpitations | YES | NO | Arthritis/Joint pain | YES | NO |
| Bleeding Disorders/Anemia/Bleeding Tendencies related to anticoagulant therapy/DVT or PE/bruises easily | YES | NO | Anxiety/Depression | YES | NO |
| Pulmonary Disease/Sleep Apnea/cough/ Asthma | YES | NO | Stroke/Seizures/paralysis/Migraines/dizziness | YES | NO |
| Thyroid problems | YES | NO | Cancer | YES | NO |
| Diabetes | YES | NO | Infections (including MRSA)/STD’s | YES | NO |

**OTHER MEDICAL PROBLEMS:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS: (include prescription, over the counter, vitamin and herbal remedies)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES and REACTIONS: (include all medication, food, tape and latex allergies)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOSPITALIZATIONS/SURGICAL HISTORY: (include any reactions to anesthesia or experiences with post-operative nausea)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY ILLNESSES: (include any reactions with anesthesia)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY:**

Do you smoke? YES NO If so, how much per day? \_\_\_\_\_\_\_\_ How many years? \_\_\_\_\_\_\_\_

Do you consume alcohol? YES NO If so, how much per week? \_\_\_\_\_\_\_\_

Do you use any recreational drugs? YES NO If so, how much? \_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_

**WOMEN ONLY:**

Are you or could you be pregnant? YES NO

Total number of pregnancies: \_\_\_\_\_\_\_\_\_ Total number of live births: \_\_\_\_\_\_\_\_ Did you breastfeed? YES NO

Do you have a family history of breast cancer? YES NO

Have you had a mammogram? YES NO If so, when? \_\_\_\_\_\_\_ What were the results? \_\_\_\_\_\_\_\_\_

**PHARMACY INFORMATION:**

Pharmacy Name and Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.**

Patient/Parent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Policy**

*We are delighted that you have chosen our facility as a provider in your cosmetic surgical and non-surgical needs. Our goal is to provide you with useful information about our financial policy to ensure that you have the best experience possible. If you have any questions regarding this policy, please contact our Patient Care Coordinator or our Office Manager at (336) 617-8645.*

**Initial Visit**

On your initial visit, you will be asked to provide demographic information. Following that visit, periodic updates may be requested. If, during the time you are a patient at our practice, you change any of your personal information, including address, telephone number, and email address, please inform us.

**Self-Pay Accounts**

Self-pay accounts are patients who are having procedures that have been deemed “cosmetic” (considered “not medically necessary”). Self-pay patients are required to pay $50.00 (Cosmetic) or $230 (Hand) at their initial visit or consultation. **NOTE:** Cosmetic consultation fees are NON-REFUNDABLE. However, if you choose to schedule a procedure, service or purchase a product ON THE SAME DAY as your consultation, the consultation fee will be applied to the cost of your procedure, service or product.

**Fees, Outstanding Balances and Payments**

Prescriptions are not included in the cost of your cosmetic procedure. Initial pre-surgical testing (includes CBC without differential and BMP) are included in the cost of your cosmetic procedure. For the safety and well-being of our patients, Dr. Coley reserves the right to require additional pre-surgical testing. You are responsible for any medical bills arising from testing radiology, pathology, supplies or other services provided or recommended by Dr. Coley. Payment in full is required at the time of your visit. We accept cash, certified or cashier’s checks, Visa, MasterCard, American Express or Discover. Financing is also available through Care Credit and PatientFi. For more information regarding this program, please speak to a member of our staff. Personal Checkswill not be accepted as a form of payment towards cosmetic surgery, products or for any other cosmetic services. Checks returned for insufficient funds will be charged a service fee of $35.00, in addition to the original amount of the check and will be placed on a “cash only” basis.

**Disability Forms, FMLA and Other Forms**

These forms take a considerable amount of time for our staff to complete. We ask that you allow 7-10 business days for completion of these forms. There will be a charge of $25.00 due at the time the forms are received. There will be an additional fee for requests to expedite completion of these forms. Under no circumstances, can forms be completed in less than five (5) business days.

**Medical Records**

Patients are required to complete and sign a written consent prior to release of their medical records. According to North Carolina’s Statute 90-411, patients will be charged a handling fee of $10.00 and copying charges of 75 cents/page for pages 1-25, 50 cents/page for pages 26-100 and 25 cents/page for pages in excess of 100. Payment is due in advance, and we ask that you allow 7-10 business days for processing. Collaborating physicians and specialists assisting in the care of a patient will not be charged for copies of medical records.

**Refunds**

Refunds are not permitted on purchases made toward skincare products. If you are not completely satisfied, you may return your skincare with 7 days of the original purchase date. Our aesthetician will be happy to discuss replacement products OR issue you a credit on your account that may be used on future purchases. In the case of a refund, it will be refunded within 30 days of your request by e-mail to your Patient Care Coordinator.

**General Cancellation Policy:**

A credit card will be placed on file to hold any appointment you schedule with us. This credit card would be charged $50.00 if there was a no-show or cancellation w/in 48 hours of your appointment. We do run a cancellation list for our team of providers, and this would allow us time to book another patient if you are unable to make your appointment. We are happy to ensure you are set up for appointment reminders via email and/or text, this will allow plenty of time for you to call the office and reschedule an appointment if you find you have a conflict.

**Cosmetic Surgery Scheduling**

Patients scheduling cosmetic procedures are required to pay a NON-REFUNDABLE surgery deposit BEFORE scheduling their procedure. The surgery deposit is equivalent to 25% of the total quoted procedure cost. The surgery deposit will be applied to the total quoted procedure cost leaving a remaining balance that must be paid 14 days BEFORE their scheduled procedure. If the balance is not paid within 14 days of the scheduled procedure, the surgery may be cancelled or postponed.

**Cosmetic Surgery Cancellation**

For the safety and well-being of our patients, Dr. Coley reserves the right to cancel or reschedule a cosmetic procedure, if he deems it to be medically necessary.

Patients cancelling their cosmetic procedure 4 weeks or more before their scheduled procedure will receive a full refund of their surgery deposit, less $100.00 for processing and administrative fees. Patients cancelling their cosmetic procedure less than 4 weeks before their scheduled procedure will receive a refund for their surgery but will not receive a refund of their surgery deposit (25%). A credit will be issued for those patients who cancel their cosmetic procedure less than 4 weeks before their scheduled procedure, which can be applied toward the cost of a future surgery, products or other cosmetic services. After 6 months, this credit will be forfeited to the practice. **NOTE:** We understand emergencies or other extenuating circumstances may arise that may cause need for a patient to cancel their cosmetic procedure. Dr. Coley and his Office Manager will evaluate the circumstance on a case-by-case basis to determine the proper course of action.

My signature below indicates that I understand and agree to the above policy.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA AUTHORIZATION CONSENT FORM**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_ /\_\_\_ /\_\_\_

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you for treatment, payment or healthcare operations. **We take our patients’ privacy very seriously and will not disclose any information without your consent.**

I understand that as part of my care, Coley Cosmetic & Hand Surgery Center originates and maintains paper and/or electronic medical records containing my health information. I understand this information serves as:

* A basis for planning my care and treatment
* A means of communication among the health professionals who contribute to my care
* A source of information for applying my diagnosis and surgical information to my bill
* A means by which a third party payer can verify services billed were provided, and
* A tool for routine healthcare such as assessing quality and reviewing the competence of healthcare professionals

**Communication by Email and Text Message –** I understand, that during the course of my care, it may become useful to communicate by email, text message (e.g. “SMS”) or other electronic methods of communication. I am aware that these methods, in their typical form, are not considered a confidential means of communication. Should I choose to use an electronic form of communication to communicate with Coley Cosmetic & Hand Surgery Center, I understand there is a chance that a third party may be able to intercept those messages. Third parties may include, but are not limited to:

* People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages.
* Your employer, if you use your work email to communicate
* Third parties on the Internet, such as server administrators, and others who monitor Internet traffic

Do you give permission to allow Coley Cosmetic & Hand Surgery Center to use unsecured email and mobile phone text messaging to transmit your protected health information regarding your appointment reminders, health related information and marketing offers?

**( ) YES ( ) NO**

I am aware of the risks involved for transmission of my protected health information by an unsecure means and that message and data rates may apply as result from these transmissions. At any time during my care, I understand that I reserve the right to terminate my consent for communications by electronic methods, and that my care will not be affected for refusing to agree to communications by an electronic method.

**( ) YES ( ) NO**

Do you give permission for our office to discuss your health history or any medical concerns with anyone other than yourself?

**( ) YES ( ) NO**

If yes, please list the individual(s) and their relationship to you.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Should it become necessary to disclose my protected information to another entity for the above purposes, I consent to such disclosure for these permitted uses, including disclosures via fax and transcription. My signature acknowledges that I was presented a copy of Patient’s Rights and Responsibilities and Privacy Practices from Coley Cosmetic & Hand Surgery Center, PA. I am aware that a copy of this signed consent will remain on file and that it is my responsibility to inform Coley Cosmetic & Hand Surgery Center, PA of any needed changes to this consent.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_