Privacy Notice Acknowledgement (For Minor Patients)

Patient Name: _____ Date of Birth : _____
Preferred Name: _____

Guarantor (responsible party for minors): _____ Date of Birth: _____
Guarantor's Social Security Number: _____ (REQUIRED)
Guarantor Occupation: _____ Employer_____

Patient's Primary doctor: _____ ❑ Patient does not have a PCP

I grant MOD Dermatology permission to contact the following person(s) regarding patient's health care:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I prefer to be contacted by (check all that apply):
☐ Cell phone: _____
☐ Work phone: _____
☐ Home phone: _____

If I am unavailable, I give MOD Dermatology permission to leave a voicemail regarding (check all that apply):
☐ ANY of the following information:
☐ Appointment Date and Time
☐ Claims and billing information
☐ Normal Test Results
☐ Prescription/Pharmacy Information
☐ Please DO NOT leave a message under any circumstances
☐ I also give permission to MOD Dermatology to text me the above information

How did you hear about our clinic? _____

I have received MOD Dermatology's Notice of Privacy Practices. A copy has been offered to me. Signature of Parent/Legal Guardian or Guarantor: _____ Date: _____

Optional consent to treat a minor:

☐ I give permission for above patient to be seen in the office when I am not available to be present. I authorize MOD Dermatology, PC to evaluate and treat said patient. I understand a parent or legal guardian will be required to sign a separate consent for excisions, biopsies, and any invasive or surgical procedure. This consent will remain in effect for 12 months from the date of my signature.

Signature of Parent or Legal Guardian: _____ Date _____