MOD DERMATOLOGY

Privacy Notice Acknowledgement (For Minor Patients)

Patient Name: _____ Date of Birth : _____

Preferred Name: _____

Patient's Primary Doctor/Physician : _____ ❑ Patient does not currently have a PCP

Guarantor (responsible party for minors): _____ Guarantor Date of Birth: _____

Guarantor's Social Security Number: _____ (REQUIRED)

Guarantor Occupation: _____ Employer: _____

How did you hear about our clinic? _____

Emergency contact information regarding patient's health care:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I prefer to be contacted by (check all that apply):

☐ Cell phone: _____

☐ Home phone: _____

☐ Work 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

☐ Prescription/Pharmacy Information

☐ Claims and billing information

☐ Normal Test Results

☐ Please DO NOT leave any messages

☐ I also give permission for MOD Dermatology to text me the above information

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.

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: _____

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