HEIGHTS DERMATOLOGY
& AESTHETICS CENTER
"Taking Your Skin to Greater Heights"
Dr. Alpesh Desai · Dr. Tejas Desai

INFORMED PATIENT CONSENT

Please initial all of the following statements.

_____ I give my permission for the doctors and staff of Heights Dermatology & Aesthetic Center to treat me, including any biopsy or procedure(s), as deemed necessary in the exercise of their professional judgement.

_____ I understand that medical care requires my cooperation, and I will follow my doctor's orders and prescriptions. If indicated, I will make and keep appointments for follow-up care and call the office to note any changes or concerns in my condition.

_____ I authorize Heights Dermatology & Aesthetic Center to take photographs, video tape, or by other similar means to record my surgery/procedure(s). I understand that reproduction or publication of said photographs and recordings will be used for the purpose of medical/scientific study and research, education, before and after surgical portfolios, and/or documentation for my medical record.

_____ I understand that the photographs and recorded material may include appropriate portions of the body to demonstrate surgery/procedure(s) and that every effort will be made to protect my identity in those materials.

_____ I further acknowledge that all recorded media obtained is the sole property of Heights Dermatology and Aesthetic Center.

_____ I understand that Dr. Alpesh Desai is partial owner of Dayspring Specialty Pharmacy.

_____ I have read and understand the medical consent forms that have been provided to me by the doctors and the staff of Heights Dermatology & Aesthetic Center.

_____ I authorize my doctor to release any information, including the diagnosis and the records of any treatment or examinations rendered to me or my child during the period of such medical care to third party payers, including Medicare.

_____ I authorize and request my insurance company, in lieu of reimbursing me directly, pay to the doctor or medical group any benefits for services rendered.

_____ I understand that my medical insurance carrier may pay less than the actual bill for services. I agree that I may be responsible for payments of all services rendered on my behalf or my dependents.

_____ I understand I may be billed by an outside laboratory for work that is performed in this office, if my insurance company does not have a contracted lab or facility, or if services are not covered by my insurance company.

Please check and print name in one of the choices below:

❑ I, _____ have received a copy of the Notice of Privacy Practices
PATIENT NAME

❑ I, _____ have been offered a copy of the Notice of Privacy Practices, but declined to accept a copy.
PATIENT NAME

_____ _____
Signature of Patient Date