PATIENT ACKNOWLEDGMENT AND CONSENT

I have been given a copy of New Age Dermatology Center, P.A.'s Notice of Privacy Practices, version effective September 23, 2013. I consent to the uses and disclosures of my health information as outlined in the Notice.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

_____

Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of Patient: _____

INFORMED CONSENT TO PHOTOGRAPH

I, _____, give permission for Dr. Chiritescu and New Age Dermatology Center, P.A., to take photographs as deemed necessary, including disclosure to other health care providers, to further my medical treatment.

Patient Signature_____ Date_____

Witness_____ Chart number_____

FOR New Age Dermatology Center, P.A. USE ONLY

Patient signed acknowledgment of receipt of Notice of Privacy Practices:

_____Yes _____No Verifying employee initial and date_____

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

_____