BROWN DERMATOLOGY
BROWN PHYSICIANS, INC.

Initial Visit Consent

PATIENT NAME:_____ DOB: _____

I understand that as part of my care the staff of Brown Dermatology, Inc. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

HIPAA Privacy Policy

I have been offered or received a copy of the Privacy Notice. It describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. To receive a copy of any revised Notice, please ask a front desk staff person or call the Privacy Officer at 401-270-1406.

Teaching Practice

Our physicians are full-time, teaching Dermatologists at Brown Alpert Medical School and in our role as teachers you may be seen by a resident, a physician that has already completed one or more years of post-medical school training, before being seen by your attending physician.

Photo Consent

I consent to be photographed regarding the medical dermatological condition or treatment for which I am seeing my provider at Brown Dermatology, Inc. for. These photographs may be used for my own medical and dermatologic care by my provider or a representative(s) for medical education or research. If any of these photographs are published in professional journals or used for any other educational purpose, which my provider may deem appropriate, I understand that I will not be identified or compensated in connection with the use or publication of these photographs. I understand that all slides and photographs are property of Brown Dermatology, Inc. _____**(Initial)**

Consent

Brown Dermatology, Inc. has my permission to call my Preferred Phone Number to confirm appointments and may leave messages pertaining to my visits on my answering machine/voicemail or with the person answering the phone. ☐ **Yes** ☐ **No**

The Practice will not disclose patient information to anyone other than the people listed below.

If no names are given, no patient information will be discussed with anyone other than the patient.

First Visit

A COMPLETE YET DISCREET EXAMINATION OF THE ENTIRE SKIN SURFACE is strongly suggested on your first visit and after a prolonged (years) absence. We often find clues from areas of the skin other than your major concern that can help us care for you better.

Yes, I would like a medical assistant present during my visit _____**(Initial)**

No, I do not require a medical assistant present during my visit _____**(Initial)**

Print Patient Name: _____Date:_____

Signature of Patient or ResponsibleParty:_____

Responsible Party Address :_____

_____ _____

Relationship* **Print Representative Name***

***As the representative of the above individual, I acknowledge receipt of the Notice on his/her behalf.**