



**AUTHORIZATION AND DISCLOSURE STATEMENTS**

**Read** the statements below, acknowledge each statement by **initialing** on the line, and **sign** your name at the bottom.

**AUTHORIZATION TO TREAT:**

\_\_\_\_\_ I authorize Aurora Clinic /North Dakota Center for Dermatology to do exams, treatments, order diagnostic tests, and to provide me medications that the provider thinks I or \_\_\_\_\_ need to stay healthy. (name of minor / patient being treated)

**INFORMED CONSENT DISCLOSURE:**

\_\_\_\_\_ I understand I have the right to be told the reason for the treatment / procedure(s), the benefits or risks associated with it, and other treatment options.

**DISCLAIMER:**

\_\_\_\_\_ I understand there are risks with the treatment / procedures and that Aurora Clinic /North Dakota Center for Dermatology cannot be held liable for unexpected outcomes.

**ACKNOWLEDGEMENT STATEMENT:**

\_\_\_\_\_ By signing below, I acknowledge that I received Aurora Clinic /North Dakota Center for Dermatology's Notice of Privacy Practices that is effective as of December 12, 2005.

**AUTHORIZATION TO ASSIGN BENEFITS:**

\_\_\_\_\_ I hereby give authorization for payment of insurance benefits to be made directly to Aurora Clinic /North Dakota Center for Dermatology for services rendered. I understand that I am financially responsible for all charges. I certify that the information I have reported with regard to my insurance coverage is correct. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits from my insurance carrier. I further agree that a photocopy of this agreement shall be as valid as the original.

**ADDITIONAL PATIENT RESPONSIBILITY:**

\_\_\_\_\_ I understand that cosmetic procedures and cosmetic products are to be paid in full on the day services are rendered. I also understand that it is my responsibility as a patient to **check with my insurance** regarding coverage for any medical services or procedures

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