AUTHORIZATION FOR TREATMENT

By my signature below, I authorize evaluation and treatment by the doctors of Clear Medical.

I understand medicine is an inexact science and many conditions are chronic and require ongoing care. All medications have potential side effects and there are risks to any medication prescribed.

Physicians frequently treat skin growths by freezing, cauterizing with a heated needle, or excision by cutting the lesion out. I understand that there are risks to any procedure performed on the skin and that these risks include, but are not limited to, permanent discoloration of the skin, scar, or nerve damage. I consent to have these procedures as part of treatment.

I understand full skin examinations for cancer screening are performed if scheduled in advance. I recognize that most visits to the office are for consultation and evaluation. Surgeries and even minor removals need to be scheduled at a separate time.

This authorization and consent shall remain in force for all future visits.

Patient or Responsible Party Signature X_____ Date_____

I authorize the release of medical information to my primary care physician, referring physician, or consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician

Patient or Responsible Party Signature X_____ Date_____

In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in for form of cash, check or credit card. In the event of hospitalizations or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay the unmet deductible, non-covered services and copayments. In the event that your account must be turned over to collection, a $20.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature X_____Date_____

CLEAR
MEDICAL

UCLA/Marina Professional Building | 4560 Admiralty Way Suite 200 | Marina del Rey | 310.305.CLEAR