Annie Chiu, M.D.
THE DERM INSTITUTE

Acknowledgement of Privacy and Consent

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have reviewed and understood the Notice of Privacy Practices. I know I have a right to obtain a copy for my records.

Patient Signature: _____

Patient Name (print): _____ Date: _____

Consent for Evaluation, Examination, and Treatment

By signing below, I authorize the evaluation, examination, and treatment by Dr. Chiu and her staff. I consent to treatment necessary for my dermatologic care. Skin growths may be treated by freezing, cortisone injections, snip removal, extractions and/or electrocautery with a heated needle. A skin biopsy (taking a small sample of skin under local anesthesia) may be used for diagnosis. I understand I can refuse any procedure.

I understand that there are risks to any procedure, including, but are not limited to:

- Bleeding
- Pain
- Infection
- Scar
- Discoloration (temporary or permanent)
- Rarely, nerve damage

I consent to having these procedures done as part of my evaluation and treatment.

By my signature below, I also understand the following:

- Total body examinations for skin cancer screening are performed if specifically scheduled in advance as this may require additional time.
- I understand that most clinic visits are scheduled for consultation of a specific skin condition. Procedures, even minor removals, usually need to be scheduled at a separate time. The Derm Institute will try to accommodate procedures if time permits.
- I am aware that there are potential risks to any treatment or medication (oral or topical) prescribed. Dermatological conditions are often chronic in nature and may require ongoing care and for me to schedule follow up appointments.

This authorization and consent shall remain in force for this and all future visits to The Derm Institute.

Patient Signature: _____

Patient Name (print): _____ Date: _____