BLUE WATER
DERMATOLOGY

2339 Medico Ln, Suite 101
Viera, Florida 32940
321-406-8615
welcome@BWDermFL.com

Consent to Treat

I voluntarily consent to examination and to routine dermatologic care by the physicians, physician assistants, and advanced practice registered nurses of BW Dermatology PLLC, d/b/a BlueWater Dermatology ("the Practice"), practicing within the scope of their license and under appropriate physician supervision.

This consent includes, without additional written consent, the following office-based services when performed under topical or local anesthesia: history and physical examination; diagnostic testing, including skin biopsies, scrapings, and cultures; cryotherapy; administration of medications customary to these services, such as local anesthetics and topical agents; and other minor procedures customarily performed in an outpatient dermatology office.

Before any such service, my treating clinician has explained, in terms I understand: (a) the nature of the proposed examination, testing, or treatment; (b) the medically acceptable alternatives, including the alternative of no treatment; and (c) the substantial risks and hazards recognized by other dermatology providers under similar circumstances. I have had the opportunity to ask questions, and they have been answered to my satisfaction. I understand I have the right to ask questions about any proposed treatment and the right to refuse any treatment.

I understand that any tissue, fluid, or specimen obtained during my visit (e.g., a biopsy) will be sent to an outside, independent pathology or reference laboratory for evaluation. That laboratory bills separately from the Practice, and I am financially responsible for its charges regardless of whether or how my insurance reimburses those charges.

If I am unable to give consent in an emergency arising during my visit, I authorize the Practice's clinical staff to provide the treatment reasonably necessary to address that emergency.

I understand I may withdraw this consent at any time, as to any future care, by notifying the Practice in writing. I understand that the practice of medicine is not an exact science and that no guarantee has been made to me regarding the outcome of any examination or treatment.

I have read this form, or it has been read to me, and I have had the opportunity to ask questions. I am the patient, or I am legally authorized to consent on the patient's behalf (parent, legal guardian, or health care surrogate/attorney-in-fact), and I am signing on that basis.

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