Women's & Family Care Cosmetic Dermatology Patient Consent and Authorization

CONSENT FOR TREATMENT I voluntarily consent to the rendering of care, including treatments, administration of anesthetics and performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of the attending/collaborative physician(s) and it is the responsibility of the staff to carry out the instructions of such Providers(s).

INSURANCE and PAYMENT I understand that this service is not covered by any insurance company. *I, the patient, am responsible for my paying bill in advance of being seen by the provider for all services rendered*I will not submit any claim to my insurance company. No refunds or discounts based on insurance EOB's will be made.

NO SHOW I understand that I am required to pay the full amount of my scheduled visit if I do not come in for or am not available for the appointment or if I cancel with less than 48 hours notice.

RELEASE OF INFORMATION Any release of my medical records will require signed authorization from me, the patient or the patient's legal guardian.

GENERAL RELEASE Women's & Family Care maintains insurance as required by the State of Kansas. *Women's & Family Care's liability to me the patient for any indemnity commitments or for any damages arising in any way out of the performance of this contract is limited to such insurance coverages and amounts. In no event shall Women's & Family Care be liable for any indirect, special or consequential loss or damage arising from the performance of services hereunder including, but not limited to, loss or use, loss of profit, economic damages, guilt and suffering, whether caused by the negligence of Women's & Family Care, or otherwise, and I, the patient shall indemnify (cover) and hold Women's & Family Care harmless from any such damages or liability. I, the patient agree to indemnify (cover) Women's & Family Care for all attorneys' fees, court costs, and all related expenses incurred by Women's & Family Care as a result of any claims made against Women's & Family Care by me, the patient or my agents.* I understand that the waiver includes any claims based upon negligence, action or inaction of its employees. I agree to indemnify (cover) and hold Women's & Family Care harmless from sequelae of medical conditions, outcomes or medications not expressly disclosed to Women's & Family Care in writing during my first consultation.

Witness	Date	Patient	Date