PREMIER DERMATOLOGY
MEDICAL · SURGICAL · COSMETIC
A FOREFRONT DERMATOLOGY PRACTICE

Incapacitated Patient Consent Form

Patient's name: _____ **Patient's date of birth:**_____/_____ /_____

It is always desirable and recommended that a legal guardian/ Durable Power of Attorney (DPOA) attend an incapacitated patient's appointment. Unfortunately, due to informed consent and contracting laws, we cannot treat the incapacitated patient until we have informed you of the specific diagnosis and suggested treatment they require and then receive your consent and approval. **If a legal guardian/DPOA is not present at the time of an incapacitated patient's appointment, the patient can only be evaluated, and only if a legal guardian/DPOA consents to the evaluation in advance by completing Section 1 below. Unfortunately, no treatment for a newly discovered condition can occur until authorized by a legal guardian/DPOA after receiving the appropriate information.**

1. **Evaluation authorization** by legal guardian/DPOA only: (***Check one box only)***

☐ I will be attending all appointments with the incapacitated patient and do not want the incapacitated patient evaluated unless I am present.

☐ I will not be attending follow up appointment(s) with the incapacitated patient and give consent and approval for any evaluation deemed appropriate by the provider. I understand that unless I am immediately available to consent or approval to any additional treatments, the incapacitated patient will need to come back for additional treatment after I provide the necessary authorization and consent.

2. **Treatment authorization** by legal guardian/DPOA only: (***Check one box only)***

☐ I will be attending all appointments with the incapacitated patient and will be present to give consent for and approval if a procedure is recommended. You may not treat the incapacitated patient without my consent or approval at the time of treatment.

☐ I will not be attending follow up appointment(s) with the incapacitated patient and give consent for and approval for ongoing care of any previously diagnosed conditions for which I have already provided authorization.

3. **Insurance information:**

If you ***are*** attending the appointment with the incapacitated patient, please present the insurance card(s) and photo identification to the receptionist.

If you ***are not*** attending the appointment(s) with the incapacitated patient, please have the incapacitated patient bring the card(s) to the appointment or attach a copy of the card(s) to this form. Also, send along any co-payments.

Name of guardian/DPOA:_____ Guardian's/DPOA's date of birth:_____/_____/_____

Guardian's/DPOA's relationship to patient: _____

4. **Payment Policy:**

The legal guardian/DPOA who signs this form will be responsible for all co-payments and deductibles. We do not forward bills to other parties regardless of court rulings. We will only respond to a court order that directs Forefront Dermatology to act in a certain way.

Guardian/DPOA Signature: _____ Today's Date:_____/_____ /_____

5. **Guardian's/DPOA's Contact information:**

Guardian/DPOA (please print):First name_____Last name _____

Phone (8 am-5 pm):_____-_____-_____ home / mobile / work (circle one)

Secondary # (8 am-5 pm):_____-_____-_____home / mobile / work (circle one)

6. **Copy of DPOA Obtained:** ☐ Yes ☐ No

This consent must be signed in addition to obtaining a DPOA.