TOLL FREE
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OFFICE
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Renew DERMATOLOGY
"Renew The Skin You're In"

PHYSICAL ADDRESS
60 MAIN STREET, STE H
FRISCO, CO 80443

MAILING ADDRESS
265 DILLON RIDGE RD, STE C402
DILLON, CO 80435

Patient Contact Consent & Care Plan Update Form

There are times we may need to contact you about your care but cannot reach you personally. Under the HIPAA guidelines, we are required to obtain written permission regarding leaving voice or text messages concerning your care. This is to make certain that every effort is made to protect the confidentiality of your medical records and only communicate with you as you prefer.

Renew Dermatology is now able to give you multiple options to make your billing process with our office seamless and easy. By filling out & signing the form below, you are consenting to having the below information shared with our billing company to have any communication from our office sent to you electronically and via USPS mail.

By putting my phone number AND initials below - I consent to being called and/or receiving a text concerning Appointments and other care related concerns (please note that any charges for text messages is the responsibility of the patient solely).

PHONE NUMBER : _____ PATIENT INITIALS:_____

Are you agreeable to having any other communication from Renew Dermatology & our Billing Company sent to your email address or phone number listed on this form?
THIS DOES NOT INCLUDE PROMOTIONAL MATERIAL YES or NO (please circle one)

Do you agree to have information including but not limited to outstanding balances, invoices, pictures, or any other patient paperwork sent to you via email or text? Please mark any of the following:

Yes, Email ☐ Yes, Text ☐ No ☐

Please Provide your Primary Email address where you would like to receive information from our office:
_____ PATIENT INITIALS:_____

EMERGENCY CONTACT INFORMATION: Please indicate the information below for the individual listed on your Advanced Care Directive or whom we can call on to make a medical decision on your behalf if necessary.

Emergency Contact First and Last Name: _____
Phone Number: _____
Contact's Relationship to you: _____

By signing below, you understand that the above information provided and understand that you may make changes to these directives at any time by providing written instructions to this office.

_____ _____ _____
Patient or Legal Guardian Signature Name of Patient:(Print) Date

_____
Name of Legal Guardian if applicable:

I attest that the above-mentioned individual has filled out this form completely and I have reviewed their answers verbally with the patient or their legal guardian to ensure we are following their wishes. I confirmed that the person understood the nature of the release with all questions answered and freely gave his or her written consent.

_____ _____
Required Signature of Renew Dermatology Staff Member Witness: Date: