Adult & Pediatric
Dermatology

Summit Dermatology
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PATHOLOGY & LAB RESULTS

Patient Name (please print) _____ Date of Birth _____

If our providers find it necessary to do any of the following: biopsies, removals or order labs, the results of these tests may be given to you by a call to the phone numbers you have listed on your demographic form. **We will not** leave a message with the actual pathology or lab result on your voicemail/answering machine. Instead, we will leave a message asking for you to call us back when it is convenient for you.

The time frame in which we receive these results can vary. However, the normal time frame for results is 10-14 days. If special tests are ordered, this can prolong the delivery of your test results to our office. **If you have not heard from our office within 2 weeks of your appointment please call for results, unless told otherwise by a nurse or provider at your appointment.**

It is important that we know where you are comfortable having a message left if we are unable to reach you by phone. Please SELECT one of the following options and answer any corresponding questions regarding whom we may talk to and where we can leave messages.

1. I DO CONSENT TO LEAVE A DETAILED MESSAGE AND/OR DISCUSSION:
I give Summit Dermatology, P.C. and their staff permission to leave messages on, or to discuss my medical care and/or billing account with, the following:

My home phone voice mail # _____ Medical Care _____ Billing Account _____
My cell phone voice mail # _____ Medical Care _____ Billing Account _____
My work phone voice mail #_____ Medical Care _____ Billing Account _____
My spouse (name)_____ Medical Care _____ Billing Account _____
Other (name)_____ phone # _____ Medical Care _____ Billing Account _____

Signature (patient or responsible party) _____ **Date** _____

2. I DO NOT CONSENT TO LEAVE DETAILED MESSAGES:
I would like to be contacted personally, I do not authorize Summit Dermatology, P.C. or any of its employees to leave messages or have discussions regarding my medical care and/or billing account with anyone other than myself.

Signature (patient or responsible party) _____ **Date** _____

PHARMACY

PLEASE LIST THE PHARMACY OF CHOICE BELOW. THIS IS WHERE ALL YOUR PRESCRIPTIONS WILL BE CALLED INTO FOR YOUR CONVENIENCE.

PHARMACY NAME: _____

CROSS STREETS: _____