



**Privacy Notice Acknowledgement (For Minor Patients)**

Patient Name: \_\_\_\_\_ Date of Birth : \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Patient's Primary Doctor: \_\_\_\_\_  Patient does not currently have a PCP

Guarantor (responsible party for minors): \_\_\_\_\_ Guarantor Date of Birth: \_\_\_\_\_

Guarantor's Social Security Number: \_\_\_\_\_ (REQUIRED)

Guarantor Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

***I grant MOD Dermatology permission to contact the following person(s) regarding patient's health care:***

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**I prefer to be contacted by (check all that apply):**

Cell phone: \_\_\_\_\_  Work phone: \_\_\_\_\_

Home phone: \_\_\_\_\_

**If I am unavailable, I give MOD Dermatology permission to leave a voicemail regarding (check all that apply):**

- |  |  |
|--|--|
| <input type="checkbox"/> ANY of the following information: | <input type="checkbox"/> Normal Test Results circumstances       |
| <input type="checkbox"/> Claims and billing information    | <input type="checkbox"/> Prescription/Pharmacy Information       |
| <input type="checkbox"/> Appointment Date and Time         | <input type="checkbox"/> Please DO NOT leave a message under any |

I also give permission to MOD Dermatology to text me the above information

How did you hear about our clinic? \_\_\_\_\_

**I have received MOD Dermatology's Notice of Privacy Practices. A copy has been offered to me.**

Signature of Parent/Legal Guardian or Guarantor: \_\_\_\_\_ Date: \_\_\_\_\_

**Optional consent to treat a minor:**

I give permission for above patient to be seen in the office when I am not available to be present. I authorize MOD Dermatology, PC to evaluate and treat said patient. I understand a parent or legal guardian will be required to sign a separate consent for excisions, biopsies, and any invasive or surgical procedure. This consent will remain in effect for 12 months from the date of my signature.

Signature of Parent or Legal Guardian: \_\_\_\_\_ Date \_\_\_\_\_

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