MR#:_____

PATIENT ACKNOWLEDGMENT FOR FOLLOW-UP CARE

I am the patient or the patient's representative with legal authority to execute this Acknowledgement on behalf of the patient. The patient has participated in a screening at DermOne Dermatology Centers, DermOne Skin and Scarless Vein Center, Scarless VeinCare or their affiliates (collectively, the "**Practice**") relating to varicose veins, venous disease and/or venous insufficiency. The patient may decide to seek further care from the Practice. In doing so, I understand and acknowledge the following:

1. I understand that the screening was offered without obligation. Specifically, I understand that the patient is not obligated to receive further care or treatment from the Practice or to follow up with any particular specialist.

2. I have been advised by the Practice to seek appropriate follow up care from the patient's regular healthcare provider or another appropriate healthcare provider of my own choosing. I understand that the patient is not obligated to receive such healthcare from the Practice. The Practice did not coerce, induce, direct or otherwise encourage me or the patient to receive follow up care from the Practice. The Practice has provided me with a list of other providers who can provide appropriate follow up care based on the results of the screening.

NOTE: *THIS LIST IS PROVIDED AS A COURTESY ONLY. IT MAY NOT BE COMPREHENSIVE, ACCURATE OR UP TO DATE. ALL PATIENTS SHOULD SELECT THEIR OWN PROVIDER BASED ON THEIR OWN INDEPENDENT RESEARCH AND DISCUSSIONS WITH THEIR PRIMARY HEALTHCARE PROVIDER.*

Coastal Surgery Specialists *1411 Physicians Drive* *Wilmington, NC 28401* *910-343-0811*	*University Physicians* *2221 S. 17th Street* *Wilmington, NC 28401* *910-815-5081*
Duke Vein Clinic *3475 Erwin Road* *Durham, NC 27705* *866-579-9484*	*Vein Care of Central North Carolina* *162 Mine Lake Court, Suite 100* *Raleigh, NC 27615* *866-601-9715*
Mid-Carolina Surgery, Vein, and Aesthetics *9336 Blakeny Centre Drive, Suite 100B* *Charlotte, NC 28277* *704-312-1003*	*Wilmington Surgical Associates* *1414 Medical Center Drive* *Wilmington, NC 28401* *910-763-7363*
Triangle Vascular Associates *2501 Weston Parkway* *Cary, NC 27513* *919-677-9729*	

3. Should I decide to seek follow up care from the Practice, I will have come to this decision independently, based on my own research and discussions with my own healthcare provider, and not as a result of any inducement or offer from the Practice. The Practice has not offered any inducement to receive care at the Practice, nor has the Practice solicited me as a patient. I understand that I may terminate my care at the Practice at any time and transfer my care to another healthcare provider of my choice.

4. **WAIVER: By initialing below, I am acknowledging that if I elect to become a patient of the Practice, I understand that I will be financially responsible for any charges resulting from any follow up care and/or testing completed. _____**
(Patient initials)

I have read and acknowledge that the above statements are true and correct. I certify that I am a competent adult of at least 18 years of age.

_____
Signature of Patient or Authorized Representative Date

_____
Relationship to Patient

Patient Name: _____

Date of Birth: _____

Insurance Plan: _____