INFORMED CONSENT FORM: GENERAL MINOR PROCEDURES NECESSARY TO THE PRACTICE OF DERMATOLOGY

Your doctor has recommended you undergo medical treatment, administration of local anesthesia and the performance of procedures and/or minor surgery. Please read this document carefully. Before signing this document, please ask your physician about any aspect of this document, or the procedure, that you do not understand.

- I do hereby authorize the use of and the administration of such drugs, anesthetics, and other treatments, including the performance of a skin biopsy, the use of cryosurgery with liquid nitrogen, and the injection of intralesional or intramuscular cortisone (a steroid), should any of these be deemed advisable, desirable, or necessary for diagnostic, therapeutic, or investigational purposes by any physician, physician extender or appropriately trained and/or licensed heath care personnel on the staff of the Skin Dermatology, for or upon me, an individual to which I am designated the guardian or guarantor, or my minor dependent child.
- I further consent to the examination for diagnostic, investigational purposes, and disposal by authorities of Skin Dermatology or its designates herein, of any tissue or parts which may be removed.
- I understand that the skin biopsy involves removal of a piece of skin and that such removal may result in a permanent scar or in discoloration of the skin at the site of the biopsy. I further understand that more than one biopsy may occur during this visit.
- I understand that all specimens removed are sent for dermatopathologic analysis and that the charges for dermatopathology will be billed to my insurance. However, I understand that in certain cases, I may be responsible for a portion or all of the charges.
- I understand that the destruction with liquid nitrogen of precancerous lesions, which are also known as actinic keratoses or solar keratoses may be deemed necessary by a member of the medical staff of Skin Dermatology, to prevent the risk that these lesions evolve into Squamous Cell Carcinomas.
- I understand that the destruction by liquid nitrogen of warts or mollusca may be advised, but these types of lesions are not cancerous and do not necessarily have to be treated. I recognize that because they may be contagious, they may recommended to be treated. Should a member of the medical staff of Skin Dermatology, recommend destruction of these lesion by liquid nitrogen, catharidin or other destructive method, I consent based on that advice. I am aware that these lesions may require more than a single treatment.
- I understand that the injection of cortisone for the treatment of scars, cysts, acne, and inflammatory conditions like psoriasis, atopic dermatitis, and alopecia areata, may be deemed necessary, advisable or desirable by a member of the medical staff of Skin Dermatology.

- I understand that any of the above procedures may have some unwanted effects, which include, but are not limited to permanent scarring, permanent discoloration of the skin at the site of treatment, atrophy (thinning or depression of the skin), infection, bleeding, nerve damage resulting in temporary or permanent numbness or temporary or permanent loss of function of certain muscles (paralysis).
- I recognize the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.

I CERTIFY THAT I HAVE READ, FULLY UNDERSTOOD AND RECEIVED A COPY OF THE ABOVE CONSENT AND THAT I HAVE RECEIVED CLEAR EXPLANATIONS REGARDING THE PROVIDED INFORMATION.

Patient*:_____ Date _____

Witness:_____ Date _____

* Parent or legal guardian if patient is under age 18 or unable to authorize consent.