ART OF DERMATOLOGY
MEDICAL • SURGICAL • COSMETIC

Informed Consent for Procedure Cryotherapy, Biopsy, Excision, ED&C

My signature on this form authorizes the physicians, physician assistants, and nurse practitioners at Art of Dermatology to perform the following procedures as deemed necessary during my medical dermatology visits with her: biopsy, excision, electrodessication and curettage, and/or cryosurgical treatment.

I have been informed and I understand the nature of the procedure and why it is necessary.

- I have been informed and I understand the risks inherent to the performance of any surgical procedure such as loss of blood, infection, reaction to anesthesia, numbness and/or lack of sensation, permanent motor/sensory nerve damage, and the formation of thick or otherwise objectionable scars. I realize that these, or other natural complications may result from the surgical procedure and no particular cosmetic outcome can be guaranteed.
- I authorize the administration of anesthesia as the physician or any associates may judge necessary or desirable.
- I also consent to the disposal of any tissue or parts which may be necessary to remove during such operation/procedure.
- I give my permission to have any tissues(s) removed during the procedure sent for histologic examination by a pathologist.
- I consent to the taking of any photographs for proper medical documentation or for teaching purposes. I authorize the release of these photos to my insurance carrier should they request in order to process my claim.
- I understand that my records may be reviewed for cases of peer review and continued quality monitoring by physicians who may not be employed and/or part of this facility.
- I hereby certify that I have provided and discussed all medical history with the physician and staff. I also hereby certify that I have read and fully understand the above authorization and consent to have this procedure done, the reasons why the above procedures are necessary, its advantages, its risks, and possible complications, if any, as well as possible alternative treatments, which were explained to me. I also understand that no guarantee has been made as to the results that may be obtained from the operation/procedure.

Sign: _____

Date: _____