CONSENT TO TREAT

During your visit, the dermatologist may need to perform cryosurgery or a skin biopsy to treat or evaluate your skin condition. Please review and sign the consent form below. You will be given ample time to discuss the procedure if the doctor determines cryosurgery or a biopsy is necessary. This will serve as a standing consent for this and any and all future treatments, however verbal consent will always be obtained prior to any treatment.

CONSENT FOR: CRYOSURGERY OR BIOPSY PROCEDURE

NAME OF PATIENT: _____ DOB: _____DATE:_____
(Please Print)

PURPOSE:

A biopsy is a surgical procedure used to obtain a sample of tissue for microscopic examination to aid the physician in diagnosis. The entire lesion may not be removed in this procedure. Further medical or surgical treatment may be needed when the diagnosis is made.

Cryosurgery is the use of liquid nitrogen to freeze the skin lesions that respond well to sub-zero temperatures. The process freezes potential skin cancers know as actinic keratosis or solar keratosis. The treatment is also used to freeze the virus infection that may cause common warts.

PROPOSED TREATMENT:

I understand that a biopsy requires obtaining a sample of tissue and is a surgical procedure. As in any surgical procedure, there are certain risks including bleeding, post-operative pain, infection, reaction to sutures, anesthetic or topical antibiotics, and scarring. Although all reasonable efforts will be made to minimize the possibility of potential complications, no guarantee can be made since many factors beyond the control of the physician (such as the degree of sun damage or patient compliance with post-operative instructions) affect the ultimate healing.

A pathologist will examine the tissue obtained in the biopsy procedure. I understand I may receive a separate bill from the pathologist or a laboratory for this microscopic examination.

Complication of applying liquid nitrogen to the skin may include:

•Irritation •Redness •Temporary discomfort •Blistering •Permanent loss of pigmentation
After the lesion has been treated, most patients develop a blister or scab that last for 1-2 weeks.

OTHER ACKNOWLEDGEMENT DISCLOSURE

I AM ABLE TO READ AND UNDERSTAND English. I understand that I will have the opportunity to discuss my procedure with the physician or other professional who is to perform the procedure and have all my questions answered to my satisfaction.

PHOTOGRAPHIC CONSENT

I AUTHORIZE AND CONSENT TO THE TAKING OF A SERIES OF PHOTOGRAPHS OF THE SURGICAL AREAS FOR THE USE OF DR. CLEAVER FOR MY CHART, IN LECTURING, PUBLICATION OF TELEVISION.

If patient is a minor, the above patient has my permission to be seen and treated accompanied by guardian or other adult (this visit and future visits.) I understand that I will be responsible for the bill, should insurance not pay, even if I am not present at the time of patients visit.

Signature of Parent or Legal Guardian: _____DATE:_____

CONSENT:

PATIENT OR LEGAL GUARDIAN SIGNATURE: _____DATE:_____

PHYSICIAN SIGNATURE: _____DATE:_____

WITNESS/NURSE SIGNATURE: _____DATE:_____