Advanced Dermatology & Cosmetic Surgery

Informed Patient Consent

I give my permission for the Doctors and staff of *Advanced Dermatology & Cosmetic Surgery* to treat me, including any biopsy or procedure(s), as deemed necessary in the exercise of their professional judgment.

_____ I understand that medical care requires my cooperation, and I will follow my doctor's orders and prescriptions. If indicated, I will make and keep appointments for follow-up care and call the office to note any changes or concerns in my condition.

_____ I authorize my physician and *Advanced Dermatology & Cosmetic Surgery* to take photographs/video tape or by other similar means record my surgery/procedure(s). I understand that reproduction or publication of said photographs and recordings will be used for the purpose of medical/scientific study and research, education, before and after surgical portfolios and/or documentation for my medical record.

_____ I understand that the photographs and recorded material may include appropriate portions of the body to demonstrate surgery/procedures(s) and that every effort will be made to protect the patient's identity in those materials.

_____ I further acknowledge that all recorded media obtained is the sole property of *Advanced Dermatology & Cosmetic Surgery*.

_____ I authorize my doctor to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical care to third party payers, including Medicare, unless otherwise protected under HIPAA, which requires my written authorization for release"**.**

_____ I authorize and request that my insurance company, in lieu of reimbursing me directly, pay to the doctor or medical group any benefits for services rendered.

_____ I understand that my medical insurance carrier may pay less than the actual bill for services. I agree that I may be responsible for payment of all services rendered on my behalf or my dependents.

_____ I understand I may be billed by an outside laboratory for work that is performed in this office, if my insurance company does not have a contracted lab or facility, or if services are not covered by my insurance company.

_____ In the event that I chose to provide Advanced Dermatology & Cosmetic Surgery ("ADCS") with my e-mail address, I hereby authorize ADCS to contact me using the e-mail address(es) I provide, and agree to allow ADCS to continue to contact me using e-mail until I advise ADCS, in writing, that they can no longer contact me using e-mail. In return for allowing ADCS to contact me using e-mail, ADCS promises not to release, sell or otherwise distribute any e-mail address(es) I provide to any other person or entity without my express written authorization

_____ I have read and understand the medical consent forms that have been provided to me by the doctors and staff of *Advanced Dermatology & Cosmetic Surgery*.

_____ _____
Patient Name (Print) Date

_____ _____ _____
Signature of patient or patient's legal guardian Witness Date

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My signature on this form authorizes Dr. _____ or_____ PA/NP (Physician Assistant / Nurse Practitioner) to perform the following procedure(s):

___ Shave Biopsy	**___ Cosmetic Shave Removal**	**___ Electrodessication**	**___ Cosmetic Punch Excision**
___ Punch Biopsy	**___ Cosmetic Skin Tag Removal**	**___ Incision and Drainage**	**___ Intramuscular Steroids**
___ Cryotherapy	**___ Intralesional Steroid Injection**	**___ Canthacur PS**	**___ Other _____**

I have been informed, to my satisfaction, regarding the nature of the procedure and why it is necessary.

I have been informed, to my satisfaction, regarding the risks inherent to the performance of any surgical procedure such as loss of blood, infection, reaction to anesthesia and the formation of thick or otherwise objectionable scars and I realize that such, or any, natural complications may result from the surgical procedure.

I give permission to have any tissue(s) removed during this procedure to be sent for histologic examination by a pathologist.

I have been informed, to my satisfaction, regarding the risks inherent to the performance of the procedure such as pain, swelling, redness, blister formation, discoloration, possible scarring and recurrence.

I have been informed, to my satisfaction, regarding the risks inherent to the performance of the procedure such as thinning of the skin, discoloration, atrophy, infection, possible scarring and recurrence.

I have been informed, to my satisfaction, regarding the risks inherent to the performance of the procedure such as weight gain, insomnia, swelling of the lower legs, increased blood sugar, increase in blood pressure, acne, cataract formation, avascular necrosis of the hip, thinning of the skin, and exacerbation of underlying infections or malignancy.

_____ _____
Patient Name (Print) Date

_____ _____ _____
Signature of patient or patient's legal guardian Witness Date

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Signature Date