



H2 DERMATOLOGY

## Consent for Treatment & Clinical Procedures

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I hereby consent to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. This may include, but is not limited to laboratory procedures (including diagnostic testing such as lab draws and skin biopsies), medical and surgical treatment or procedure (including wart treatments, surgical removals, or excisions), or other services rendered during my appointment.

In order to ensure that you understand all aspects of your visit, you are encouraged to ask any questions or clarify any procedures prior to them being performed. Our dermatology providers will answer any questions and discuss any procedures, concerns and goals with you in regard to the following: benefits of the proposed procedure, the way the treatment or procedure is to be performed, alternative treatment options, probable consequences of not receiving the treatment, the right to withdraw informed consent at any time, in writing, risk and side effects involved with the procedure, potential for additional incurred charges.

Should a biopsy be performed, or any other procedure in which a section of your skin is removed, the specimen **will be** sent to a pathology lab for an accurate diagnosis, unless otherwise recommended by your clinician. This process will involve any testing necessary including special staining or outside consultations which will incur additional charges. \_\_\_\_\_ **(Initials)**

I acknowledge that some medical diagnoses (such as warts) will require multiple treatments with one or more methods that may change throughout the course of treatment and each office visit and procedure will be billed accordingly. \_\_\_\_\_ **(Initials)**

I acknowledge that with any procedure, there are risks involved which include, but are not limited to the following: scar, infection, bleeding, and nerve damage. \_\_\_\_\_ **(Initials)**

I authorize pictures to be taken before, during and after the procedure. These pictures will become part of your medical record. They may also be sent to your family physician and/or referring physician. They will not be used for any other purpose without a proper consent. \_\_\_\_\_ **(Initials)**

If a complication after the procedure would arise, there may be a charge for the medical management that will be submitted to your insurance company. I recognize that the practice of medicine is not an exact science and acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures or treatments. \_\_\_\_\_ **(Initials)**

I have read the consent form in its entirety. I understand the risks associated with procedures that may occur during my visits at H2 Dermatology. I do not impose any limitations on H2 Dermatology and its staff. I understand that I should discuss any questions or concerns with my dermatology provider prior to any procedure and therefore; with my signature, agree to have any necessary procedures performed.

\_\_\_\_\_  
**Patient signature / Date**

*The undersigned hereby provides consent as the parent or guardian of the above referenced minor patient.*

\_\_\_\_\_  
**Parent or Guardian signature/ Date**

\_\_\_\_\_  
**Relationship to Patient**