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VELARTSE / DERMATOLOGISTS

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CONSENT TO MEDICAL/SURGICAL OFFICE PROCEDURE

I _____, consent to the medical/surgical procedures outlined below to be performed by _____ and her staff, associates, or assistants to whom the physician(s) performing the procedure may assign designated responsibilities. In the event one or more of the physicians is unable to perform or complete the procedure, a qualified substitute physician will perform or complete the procedure.

The proposed medical/surgical procedure is _____

_____

for the diagnosis/treatment of :

_____

The procedure has been explained to me in terms that I understand. The explanation included:

- The nature and extent of the procedure to be performed.
- The most frequently occurring risks of the procedure involved, and those risks which are unlikely to occur but which may involve serious consequences, include but are not necessarily limited to the following: bleeding, infection, damage to adjacent tissues or organs, swelling, pain, suture reaction, delayed healing, scarring, anesthesia or medication reaction, recurrence, additional operations, and in rare instances paralysis or death.
- The benefit of the procedure.
- The estimated period of incapacity or convalescence, if any.
- The risks and benefits of any reasonable alternatives to this procedure, including having no treatment at all.

I was given the opportunity to ask any questions I have regarding the procedure and I have had those questions answered to my satisfaction.

I understand that I may consult or could have consulted with another physician about this procedure.

I understand that I have the right to refuse any medical/surgical treatment recommended at any time prior to its performance.

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I authorize my physician to perform such additional procedures which in her judgment are incidentally necessary or appropriate to carry out my diagnosis/treatment.

If any unforeseen condition arises during this procedure which requires transportation to a hospital, additional procedures, operations or medication including anesthesia and blood transfusions, I further request and authorize my physician to do whatever she deems advisable on my behalf.

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of this procedure.

I do not have allergies or intolerance to anything except: _____.

I authorize the physician performing the procedure, or her staff, associate, or assistant to whom the physician may assign the responsibility, to use his or her discretion in disposing of or using any tissue of body parts that may be removed during the procedure set forth above, subject to the following conditions (if any): _____

I consent to administration of such anesthetics may be considered necessary or advisable for this operation or procedure.

I authorize that medical photography, if performed may be utilized for medical, scientific, or educational purposes, provided my identity is not revealed in the photo or text.

I acknowledge that I have read (or had read to me) and fully understand the above information. Furthermore, I certify that all my questions and concerns regarding the procedure, its attendant risks, benefits and alternatives have been explained to my satisfaction. I hereby authorize my physician to perform the above discussed procedure.

_____ _____

Patient's name Date

_____

Patient's signature

_____

Doctor's signature

PLEASE BRING THIS SIGNED CONSENT FORM ALONG ON THE DAY OF YOUR PROCEDURE.

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