

**Informed Consent For Diagnosis and Treatment**

It is valuable and necessary that you understand the information contained in this informed consent document. If you have any questions, please know that it is your responsibility to ask for clarification before any procedure or treatment is performed on you or your dependent. If you have no questions, by signing this document you understand and agree with the following statements:

My decision to undergo this procedure or treatment (for myself or my dependent/ward) is one I made voluntarily and independently after careful consideration. I consent to the procedure or treatment (for myself or my dependent/ward) as well as any different procedure or treatment which may be indicated during the course of this procedure or treatment, or as may be necessary due to any emergency. I hereby authorize the physicians of The Dermatology Group, and its representatives and staff, to examine and treat me and perform any biopsy or other procedure/treatment as may be deemed necessary to provide dermatologic care and aid in the diagnosis or treatment of my, or my dependent/ward’s, skin condition or disorder in the office or virtually with Telehealth.

I understand that there are always certain risks and consequences associated with any healthcare procedure or treatment. Indeed, there is no way to list all the potential risks of any procedure or treatment. The most common risks of dermatology procedures and treatments are: pain, infection, bleeding, swelling, bruising, scarring, reaction to anesthesia or other allergic reactions, pigment/color changes to the skin, reoccurrence of skin cancer or other lesions/problems, damage to blood vessels or parts of the body next to blood vessels, such as nerves, skin or tissue, nerve injury that may result in no, or lessened, sensation or movement in or near a procedure/treatment site, or other complications any of which could be life threatening.

I recognize that I have the right to refuse any diagnostic or procedure/treatment services without jeopardizing my right to receive health services at The Dermatology Group. I also recognize that the practice of medicine is not an exact science and I acknowledge that no guarantee or assurance has been made to me, or in relation to my dependent/ward, any of which may be directly or indirectly related to any examination, diagnosis, procedure or treatment provided by The Dermatology Group.

I understand that any tissue/sample taken today will be sent for pathologic evaluation to a Board Certified Dermatopathologist and that this tissue/sample may be sent for additional tests or evaluation at my personal or my insurance company’s expense.

I have received, understood and agree to the instructions and disclosures contained in the Post-Treatment/Procedure Patient Instructions given to me – if any. I acknowledge that there may be a need for me to have a follow up or have long-term follow up, especially if cancerous or pre-cancerous lesions have been treated.

I authorize that The Dermatology Group’s physicians and their staff record data, including photographic records, regarding any procedure or treatment any of which will become part of my medical records, be used regarding my care, and/or medical presentations, which if so used, I hereby authorize such use without compensation to me. This also includes consent for virtual services. I understand that such data or photographic records shall never be published by The Dermatology Group in any manner that can identify me unless I give explicit approval to do so all of which will be consistent with my rights to the privacy of my medical information.

I understand that The Dermatology Group has made no assurance or guarantee to me as to any result that I can expect regarding any procedure or treatment, or whether such procedure or treatment will cure my, or my dependent/ward’s, skin disorder or condition and that indeed, it could make such condition or disorder worse. I understand that I am the only person that can ask for other options or clarifications of any procedure or treatment option presented by The Dermatology Group, and that I am free to accept or refuse the option(s) presented by my physician or to seek a second opinion. By signing below, I accept, for myself and my dependent/ward, all risks of — and financial responsibility to pay for — the procedures/treatment and any other services rendered by The Dermatology Group.

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| My signature below confirms that: (1) I have read and understand the risks, benefits, and other information set out in this document; (2) I had a chance to ask my doctor questions and that I have received all of the information I desire concerning any treatment/procedure; and, (3) I authorize and consent to the performance of Examination/diagnosis/treatment/procedures for myself, or for my dependent/ward. |
| **By:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **patient SIGNATURE**  **Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **By:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Signature of patient parent or guardian**  **Printed Name of Parent/guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**  **Printed Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |