Western Maryland Dermatology

CONSENT FOR THE GENERAL MINOR PROCEDURES NECESSARY TO THE PRACTICE OF DERMATOLOGY

AUTHORIZATION FOR MEDICAL TREATMENT, ADMINISTRATION OF LOCAL ANESTHESIA AND THE PERFORMANCE OF MINOR SURGERY AND/OR PROCEDURES

1) I do hereby authorize the use of and the administration of such drugs, anesthetics, and other treatments, including the performance of a skin biopsy, the use of cryosurgery with liquid nitrogen, and the injection of intralesional kenalog (cortisone), should any of these be deemed advisable, desirable, or necessary for diagnostic, therapeutic, or investigational purposes by , any physician, physician assistant or appropriately trained and/or licensed heath care personnel of Western Maryland Dermatology, for or upon me or my minor.

2) I further consent to the examination for diagnostic, investigational purposes, and disposal by authorities of the above named medical facility or it designates herein, of any tissue or parts which may be removed.

3) I understand that the skin biopsy involves removal of a piece of skin and that such removal may result in a permanent scar or in discoloration of the skin at the site of the biopsy. I further understand that more than one biopsy may occur during this visit.

4) I understand that all specimens removed are sent for pathologic analysis and that the charges for pathology will be billed to my insurance. However, I understand that in certain cases, I may be responsible for a portion or all of the charges.

5) I understand that the destruction with liquid nitrogen of precancerous lesions, which are also known as actinic keratoses or solar keratoses, may be deemed necessary by a member of the medical staff of Western Maryland Dermatology, to prevent the risk that these lesions evolve into Squamous Cell Carcinomas.

6) I understand that the destruction of warts or mollusca may be advised, but these types of lesions are not cancerous and do not necessarily have to be treated. I recognize that because they may be contagious, they should be treated. Should a member of the medical staff of Western Maryland Dermatology, recommend destruction of these lesion(s), I consent based on that advice. I am aware that these lesions may require more than a single treatment. I understand that scaring is possible.

7) I understand that the injection of triamcinolone (cortisone) for the treatment of scars, cysts, acne, and inflammatory conditions like psoriasis, atopic dermatitis, and alopecia areata, may be deemed necessary, advisable or desirable by a member of the medical staff of Western Maryland Dermatology.

8) I understand that any of the above procedures may have some unwanted effects, which include, but are not limited to permanent scarring, permanent discoloration of the skin at the site of treatment, atrophy (thinning or depression of the skin), infection, bleeding, nerve damage resulting in temporary or permanent numbness or temporary or permanent loss of function of certain muscles (paralysis).

9) I recognize the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.