DERMSPECIALISTS
A Forefront Dermatology Practice

Consent to 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 visit with Dermatology Associates of Wisconsin, S.C., d/b/a DermSpecialists, a Forefront Dermatology practice ("Forefront").

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)*

With any procedure, there are risks involved which include, but are not limited to the following:

- Scar – Scarring is possible with any procedure of the skin. We will do everything we can to provide you with the best cosmetic result possible, but the final cosmetic outcome is not guaranteed.
- Infection – The entire procedure will be done in a sterile and/or clean fashion. Still, a small number of people will get a wound infection.
- Bleeding – Some procedure may create some bleeding. Rarely will someone have significant bleeding after they leave such that they would have to come back to have us treat it.
- Nerve damage – This will be thoroughly discussed with you by your physician if it is a potential during your procedure.
- 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.

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.

Since each insurance company has its own policies regarding the coverage of procedures, I also acknowledge that I am responsible for payment in full for the charges incurred for procedures regardless of the coverage provided by my insurance carrier. If I am concerned about the cost associated with treatment, it is my responsibility to request a procedure estimate prior to starting treatment.

_____ *(Initials)*

I have read the consent form in its entirety. I understand the risks associated with procedures that may occur during my visits at DermSpecialists. I do not impose any limitations on DermSpecialists 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 Witness 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*