CONSENT FOR TREATMENT

I acknowledge that I (or my child) am suffering from a condition requiring medical, or surgical treatment, and do voluntarily consent to such procedures and medical care under the instruction of the Health Care Provider as judged necessary.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatment or examination. If this is a procedure or surgery the treated lesion might or might not return after treatment. *I understand the potential risks and benefits of surgery, biopsy, or any procedure include the risk of infection, bleeding, scar, discoloration, injury to nerves, muscle weakness, numbness over the skin, skin dimpling, postoperative stiffness and pain, scarring, poor cosmetic outcome, hair loss, skin color changes from the scar, and failure of the surgery or procedure to achieve its intended goals. I also understand that if an anesthetic such as lidocaine or epinephrine is used, then it can result in a potential allergic reaction, and the potential for that reaction is not predictable. The Health Care Provider has explained to me the alternatives to this particular treatment or no treatment, the risks and benefits and has allowed me to ask questions fully regarding the procedure(s). I acknowledge understanding of the risks and benefits of treatment and wish for treatment to occur as designated.*

I also acknowledge that in the course of treatment or examination, digital photographs might be taken of my skin condition. The photographs will be used for treatment, advice for treatment, or educational purposes, and I consent to such digital photographs.

Procedure:
Biopsy | Curettage and Electrodessication | Cryotherapy | Excision and Closure |

Electrodessication | Incision and Drainage | Nail Avulsion (Risk of Permanent Nail Damage)

Shave Removal | Skin Scraping | Skin Tag Removal with Electrodessication | Snip Removal

Intralesional kenalog (steroid) (risk includes skin atrophy or skin dimpling)

Other:____

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Witness Signature: ________________________________ **Date:** ____/____/____

Yahaira Chavez | Estefania Atala | Bianca Silva | Moses Flores | Karima Atala | Michelle Macias

Printed Name of Witness: ____________________________

Translator Signature: ________________________________ **Date:** ____/____/____

Printed Name of Translator: ____________________________

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Signature: ______________________________________ **Date:**____/____/____

Printed Patient Name: ________________________________ **DOB:**____/____/____