Dermatology Group of Arkansas, P.A.

CONSENT FOR TREATMENT

I hereby consent to all medical and surgical procedures, including but not limited to laboratory, biologic tests, and administration of local anesthesia which are deemed appropriate and necessary at any time while under the care of the physicians at Dermatology Group of Arkansas, P.A.

Tissue samples may be needed to diagnose your condition. Both malignant and benign growths and conditions may require a surgical procedure called a biopsy. A local anesthetic is used prior to taking this tissue sample. This simple procedure carries with it minor risks such as: allergic reactions to the anesthesia, fainting, mild discomfort, minimal bleeding, the possibility of minor scarring and infection. The risks of not having the procedure done should be discussed with the physician.

It is our policy of this office to send all surgically removed specimens for expert consultation regardless of the pre-biopsy diagnosis. You may be responsible for any charges not covered by your health insurance.

I have read the above statements and understand the risks associated with a tissue biopsy. I also agree to have a biopsy performed by the practitioner if clinically indicated and sent to a pathology laboratory for analysis. I am aware that any outside services not covered by my insurance are my responsibility. I also authorize: Dermatology Group of Arkansas, P.A. physicians to release any information regarding my examination or treatment to my insurance company for processing of claims and/or to my referring physician.

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SIGNATURE OF PATIENT (OR PARENT OR RESPONSIBLE PARTY)

_____

PRINTED NAME

_____

DATE