During your visit, the dermatologist may need to perform cryosurgery or a skin biopsy, or excision to treat or evaluate your skin condition. Please review and sign the consent form below. You will be given ample time to discuss the procedure if the doctor determines cryosurgery or a biopsy is necessary. This will serve as a standing consent for this and any future treatments, however verbal consent will always be obtained prior to any treatment.

PURPOSE

- A biopsy is a surgical procedure used to obtain a sample of tissue for microscopic examination to aid the physician in diagnosis. The entire lesion may not be removed in this procedure. Further medical or surgical treatment may be needed when the diagnosis is made.
- Cryosurgery is the use of liquid nitrogen to freeze the skin lesions that respond well to sub-zero temperatures. The process freezes potential skin cancers known as actinic keratosis or solar keratosis. The treatment is also used to freeze the virus infections that cause many common warts.

PROPOSED TREATMENT

I understand that a biopsy requires obtaining a sample of tissue and is a surgical procedure. As in any surgical procedure, there are certain risks including bleeding, post-operative pain, infection, reactions to sutures, anesthetics or topical antibiotics, and scarring. Although all reasonable efforts will be made to minimize the possibility of these potential complications, no guarantees can be made since many factors beyond the control of the physician (such as the degree of sun damage or patient compliance with post-operative instructions) affect the ultimate healing.

A pathologist will examine the tissue obtained in this biopsy procedure. I understand I may receive a separate bill from the pathologist or laboratory for this microscopic examination.

- Complications of applying liquid nitrogen to the skin may include:
- Irritation
- Redness
- Temporary discomfort
- Blistering
- Infection
- Permanent loss of pigmentation

After the lesion has been treated, most patients develop a blister or scab that lasts for 1-2 weeks.

CONSENT TO OBTAIN PATIENT MEDICATION HISTORY

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans and other healthcare providers. The collected information will be stored in my electronic medical record and becomes a part of my personal medical record. It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. By signing this consent form, you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

OTHER ACKNOWLEDGEMENT DISCLOSURE

I understand that I will have the opportunity to discuss my procedure with the physician or other professional who is to perform the procedure and have all my questions answered to my satisfaction.

PHOTOGRAPHIC CONSENT

I AUTHORIZED AND CONSENT TO THE TAKING OF A SERIES OF PHOTOGRAPHS OF THE SURGICAL AREAS FOR THE USE OF DR. FUCHS or DR. SMIRNOV FOR DOCUMENTATION OR EDUCATIONAL PURPOSES.

I agree to not photograph or record any part of my procedure during my visit today. This includes by camera, tablet, or cellular device.

***DISCLAIMER**: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.*

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____