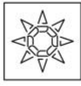

Consent for Surgical Procedure

I, ____authorize Dr. James Pehoushek, Nicole Madera, PA-C, Susan L. Iorio, M.D., M.S.P.H, Courtney Cahill, PA-C, or Dr. Tyler A. Moss, D.O. to perform the following procedure(s):

●Skin Biopsy ●Removal of skin cancer(s) ●Removal of benign lesion(s)

of (surgical site) ____.

This procedure has been explained to my satisfaction and included in the explanation was:

- The nature and extent of the procedure to be performed;
- The risks involved, including those unlikely to occur;
- Alternative methods of treatment and the dangers of those treatments.

I understand that every surgical procedure involves certain risks and possibilities of complications and those complications have been known to follow some procedures, even when the utmost care, judgment, and skill are used. I accept the risk of their occurrences. I have asked all the questions I thought were important in deciding whether or not to undergo treatment. These questions have been answered to my satisfaction.

Risks include but are not limited to:

- Permanent scars where incisions have been made, including spread of scars or keliods;
- Pain, stinging, swelling, bruising, redness, and skin discoloration;
- Blistering, crusting, long-term changes in skin color, and scar formation of lasers, peels, and electrocauter used;
- Recurrence or persistence of lesion or cancer;
- Infection, bleeding, blood clot, and nerve damage.

I understand that no assurance can be given as to the results of the procedure, permanency of results, or my satisfaction with the results. No guarantees of success have been made or implied by me. I consent to the administration of local anesthetic agents by Dr. Pehoushek , Dr. Iorio, Courtney Cahill, PA-C or Nicole Madera, PA-C., or Dr. Tyler Moss.

I consent to being photographed before, during, and after the procedure/treatment; that these photographs shall be property of Allergy & Dermatology Specialists and may be used for chart records and as deemed proper scientific and education purposes. The photos or descriptions accompanying them will not reveal my identity.

I understand that if tissue is removed, it will be sent for pathology examination and a separate fee will be incurred for services. Additional review of the tissue may be required to clarify or confirm the diagnosis. In such cases, the pathology specimen(s) may be sent for a pathological consultation. These services will be billed to me or my insurance company, by laboratories performing the service. The pathology charges are billed according to the date the biopsy or surgery specimen is read by the doctor/pathologist and not the date of procedure.

I have read and fully understood the above content for the procedure and affirm that all of my questions have been answered to my satisfaction.

____ _______________________

Patient or Legal Representative Date