CONSENT AND AUTHORIZATION FOR TREATMENT

By my signature below, I authorize an evaluation and treatment by the doctors and staff of Advanced Dermatology and Cosmetic Care.

I understand dermatology is an inexact science and many conditions are chronic and require ongoing care. All medications have potential side effects and there are risks to any medication prescribed.

Dermatologists frequently treat skin growths by freezing, cauterizing with a heated needle or excision by cutting the lesion out. I understand that there are risks to any procedure performed on the skin and that these risks include, but arte not limited to, permanent discoloration of the skin, scarring or nerve damage. I consent to having these procedures as part of the treatment.

I understand full skin examinations for cancer screening are performed if scheduled in advance. I recognize that most visits to the office are for consultation and evaluation, and surgeries, even minor removals, need to be scheduled at a separate time.

This authorization and consent shall remain in full force for all future visits to Advanced Dermatology and Cosmetic Care.

______________________________________ __________________
Signature Date

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Printed Name