Merheb Surgical Arts

# CONSENT
# FOR SKIN LESION TREATMENT

Patient_____ Date of Birth_____

Please read, initial and sign the following disclosure:

I have requested that my Doctor(s) attempt to remove my skin lesion (s) Located
_____
_____

_____ I have been informed that the practice of medicine is not an exact science and although the side effects and complications from skin lesion removal are usually minimal, no absolute guarantees can be or have been made concerning expected results in my case. Variable degrees of skin color changes and scarring can occur as a result of the treatment.

_____ Occasionally, postoperative problems occur such as unusual swelling, redness, pain, blistering, bruising, and/or infection. I have been informed of potential problems and will notify my Doctor immediately if I suspect any complications or have any concerns during the healing period.

_____ Reoccurrence or incomplete lesion removal may also occur requiring additional treatments and cost. I have been advised of the risks involved with this treatment, the expected benefits of treatment, and alternative treatments, including no treatment at all.

*I certify that I have read, and fully understand the above paragraphs, and that I have had sufficient opportunity for discussion and to ask questions.*

_____ _____
Patient's Signature Date

_____ _____
Witness' Signature Date

_____ _____
Doctor's Signature Date