Twin Peaks Dermatology, PC

BIOPSY and CRYOTHERAPY CONSENT FORM

Patient's Name: _____

Date of Birth: _____

1. I,_____, (patient or guardian) authorize Dr. Fueston to perform the following procedure(s):

   Skin Biopsy Cryotherapy (Freezing)

   I understand the reason for the procedure is: _____

   _____

2. Alternatives include: Do not perform the procedure.
3. Risks of these procedures include: Bleeding, bruising, infection, indentation of the skin, scar, pain, nerve damage, change in the sensation of the skin, change in the pigmentation of the skin, incomplete removal, recurrence, allergic reaction to the anesthetic which could be potentially life threatening.
4. I have read and fully understand this consent form. I understand that I should not sign this form if all items including all of my questions have not been explained or answered to my satisfaction or if I do not understand any terms or words contained in this consent form.

   DO NOT SIGN UNLESS YOU HAVE READ AND CLEARLY UNDERSTAND THIS FORM

5. _____ _____ _____

   Patient/Responsible Party Date Witness

6. Provider's Declaration: I have explained the contents of this document to the patient or responsible party and have answered all of the questions to the best of my knowledge. I feel that the patient has been adequately informed and has consented to this procedure.

   _____ _____

   Provider's Signature Date