Patient's Name:

Disclosure and Consent of In-Office "Surgical" Procedures

I authorize

to perform the following procedure:

Type of Procedure:

Cryotherapy (liquid nitrogen destruction of a skin lesion)
Laceration repair
Destruction of skin lesion by curettage
Excision biopsy of the skin
Ingrown toenail removal (wedge/full)
Shave excision of the skin
Punch biopsy of the skin
Incision and drainage of skin abscess
Removal of Impacted Cerumen/Foreign
Body Nail Bed Destruction
Joint Injection
Suture removal
Suture placement
Dermal Aesthetics

I understand the procedure may be performed under local anesthesia if necessary. My Doctor/Physician Assistant has explained this procedure is generally safe, but certain risks accompany any surgical procedure. Risks associated with this procedure include:

- **Bleeding and bruising in the surrounding tissues**
- **Pain associated with the procedure or the healing process**
- **Excessive scarring associated with the procedure**
- **Allergic reaction to the numbing medication or the surgical instruments or suture material**
- **Localized infection in the surrounding tissues**
- **Damage to the structures below the skin, such as a nerve or blood vessel**

You also have the right, as a patient, to be informed that the above procedure(s) may either be DENIED by your insurance company or APPLIED TO YOUR ANNUAL DEDUCTIBLE. Even though this procedure is performed in a "Medical Office", this procedure is considered a "surgical procedure" by insurance companies and may be applied to your deductible, depending on the coverage and provisions of your plan.

I have read this form and have had any questions answered to my satisfaction regarding this surgical procedure and I (we) FULLY understand that I (we) will then be responsible for what my (our) insurance company does NOT cover and/or is applied to my deductible.

Patient Name:

First Name Last Name

Patient Signature:

Today's Date:

Last modified: 03/13/2021