CONSENT FOR OPERATIONS AND SPECIAL PROCEDURES

Patient Name:_____ Date:_____

1) I hereby authorize Dr. Jeffrey Fromowitz, Dr. Judith Redd, and/or Stefanie Gold, PA-C to perform upon the above patient, the operation and/or procedures know as:

Biopsy Excision Cryotherapy

2) If any unforeseen conditions arise during the course of operation, I do hereby authorize the Doctor and his Physician's Assistant and/or Medical Assistants to take whatever steps, and to perform whatever procedures they deem advisable which may be in addition to, or different from those now planned.

3) Dr Fromowitz and/or staff have explained to me the general method of procedure, and he/she also explained to me that there are always certain risks and consequences that are associated with the aforesaid procedure and he/she explained the risks and consequences of the procedure. These, among others, are scarring, pigmentary changes to the skin, reoccurrence of skin cancer or other lesion, problem, and possible damage to blood1 vessels, or parts next to them such as nerves, infection, or allergic reactions or heart, brain, kidney, liver, lung complications, and very rarely, even death.

4) The alternatives to the operation and/or procedures have been fully explained to me and I was told that one alternative was that I could refuse the operation or procedure.

5) I acknowledge that no guarantee or assurance has been made to me as to any of the results or risks, and I assume such risk, and that the practice of medicine is not an exact science, and I understand these facts.

6) **I DO NOT** want to have further explanation, discussion, or description of the risk involved in all of these procedures.

7) I consent to the disposal by the above named physician any tissue parts which mat be removed from me. I understand that this tissue will be sent for pathologic evaluation and that I will be financially responsible for all the charges related to this evaluation regardless of the reimbursement from my insurance carrier. I also understand that I will not hold Integrated Dermatology of East Boca, LLC professionally or personally responsible for the pathologic interpretation of said tissue and that this tissue may be sent for additional tests or evaluation at my or my insurance company's expenses.

8) I consent to the taking of photographs in the course of this operation for the purpose of advancing medical education, as may be authorized by my physician, and to admittance of qualified observers to the operation room, as determined by the physician/surgeon.

9) FOR PATIENTS UNDERGOING SKIN CANCER TREATMENT: I understand that I have skin cancer and that it is my responsibility to seek follow1 up care by my dermatologist every three (3) months. Failure to seek follow-up care is my responsibility and I do not hold Dr. Fromowitz or Integrated Dermatology of East Boca, LLC personally or professionally responsible for the skin cancer follow-up.

I have read the above, I understand the words, and agree to the terms:

_____ _____

(Patient or Guardian / relationship) (Witness)

I have explained the matters indicated above relating to the operation and/or procedure and the risks, consequences, and alternatives. The patient and/or guardian verbalized and understanding and consented to the procedures described above

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(Physician/ PA-C)