Consent to Medical/Surgical Office Procedure
Elite Dermatology

By my signature below, I acknowledge the following:

I consent to the recommended medical, surgical, and/or cosmetic procedures (the "Procedure") to be performed by Elite Dermatology, PLLC.

The Procedure has been explained to me in terms I understand.

The explanation of the Procedure included:

- The nature and extent of the Procedure to be performed.
- The most frequently occurring risks of the Procedure involved, and those risks which are unlikely to occur, but which may involve serious consequences if they were to occur.
- The general risks of the Procedure, including pain, scarring, bleeding, and infection.
- The benefits of the Procedure.
- The estimated period of incapacity or convalescence related to the Procedure, if any.
- The risks and benefits of any reasonable alternatives to the Procedure, including having no treatment at all.

I had the opportunity to ask any questions regarding the Procedure, and those questions have been answered to my satisfaction.

I was given the option and opportunity to seek consultation with another provider about the Procedure.

I understand that I have may refuse any medical/surgical Procedure at any time prior to its performance.

I authorize my provider to perform such additional procedures which in his/her judgment are incidentally necessary or appropriate to carry out my diagnosis/treatment.

If any unforeseen condition arises during the Procedure which requires transportation to a hospital, additional procedures, operations, or medications, including, but not limited to, anesthesia and blood transfusions, I further request and authorize my provider to do whatever he/she deems advisable on my behalf.

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of this Procedure.

I authorize that medical photography may be utilized for medical, scientific, or educational purposes, provided my identity is not revealed in the photo or text.

I acknowledge that I have read and fully understand the above information.

I hereby authorize my provider to perform any recommended Procedure(s).

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Patient Signature ________________________________

Date______________________