CONSENT FOR NAIL PROCEDURE

Patient Name:_____

DOB:_____

This consent serves as an authorization for the administration of anesthesia and the performance of minor procedure.

Check all that Apply: ☐ Excision ☐ Mohs Surgery

PLEASE INITIAL ON THE LINE AFTER READING AND UNDERSTANDING EACH STATEMENT

_____ I understand the nature of the procedure that has been recommended.

_____ I, along with Dr. Carin Litani have verified the surgical site for today's procedure.

_____ I authorize the performance of the checked procedure(s), unforeseen conditions may necessitate additional or different procedures or services than those set forth above. I further authorize and request that Dr. Litani and her assistants perform such procedures if necessary and desirable in her professional judgment.

_____ The proposed and possible consequences of the procedure, possible alternative methods of treatments, the risks involved and the possibility of complications have been fully explained to me. I have been informed of the expected benefits as well as informed of alternative treatments.

_____ Complications of the procedure can include infection, bleeding, allergic reaction, neurologic injury, incomplete excision, scarring, and permanent nail dystrophy or complete nail loss.

_____ I consent to the administration of anesthetics that may be considered necessary or advisable by the doctor.

I hereby give my consent (voluntarily) to the procedure(s) described above.

_____ _____

Patient Signature **Date**

I give permission for a message to be left for me explaining the results of the biopsy or biopsies.

_____ _____

Initial **Telephone Number**