CONSENT

I authorize Dr. Fazeli & Dr. Broumand, LLC, their Providers and whomever they may designate as assistants, to perform on me the procedures described on this form. The Providers may treat and diagnose a variety of skin conditions through: biopsies, liquid nitrogen, electric cautery, lights, lasers and canthrone. I understand and acknowledge that medicine and surgery are not exact sciences and that no guarantee or assurance has been made to me as to the results of the procedure.

I am aware that the procedure may need to be repeated multiple times in order to achieve the best results. I also understand that scarring is a normal result of surgery and that every patient heals differently. I understand that I may need several follow up visits to assess my wound and the need for referral to a specialist in wound care. I understand that I may require multiple treatments and that no guarantees have been given to me by any of the staff.

I understand the procedure may need to be altered if any unforeseen conditions or disorder is encountered during the procedure. I authorize the Provider to use his/her judgment for procedures in addition to, or different from, those now contemplated and that he/she do whatever he/she deems advisable and appropriate to the situation.

I understand that having skin cancer increases the chances of additional skin cancers and those additional cancers can be close to the site of an old skin cancer. Any changes to my skin should be brought to the attention of my Provider. If I was referred from another office, I understand I will be referred back to that office for continuing dermatology care.

I certify that I will inform my Provider of all medications that I am currently taking or have taken, including any prescription, over the counter and herbal preparations, in the last six months. I specifically certify that I have not taken Accutane (a medication used to treat acne) in the last six months. I understand that it is my responsibility to let my Provider and staff know if there has been any change to my health or the medications I am taking at each appointment before I am treated. I certify that I will inform my Provider if I become pregnant, if I have any electrical devices implanted in my body, including but not limited to: pacemakers and internal defibrillators and any metallic implants such as joint replacements.

I am aware that I may receive and I consent to the use of local anesthesia as deemed appropriate for the procedure. I understand that anesthesia involves the administration of medications at the therapy site to numb the area. I understand that there are certain risks associated with anesthesia which include, but are not limited to: allergic reaction to the medication and soreness at the injection site, seizures and cardiac arrhythmias. I understand that certain complications may result from the use of any anesthetic, including respiratory problems, drug reaction, paralysis, brain damage, or even death.

I hereby consent to allow photographs to be taken of me before, during and after the treatment or therapy and agree that the photographs may be used for record keeping and teaching purposes, provided my identity will remain anonymous. I recognize that due to my treatment and medications there is the potential for bruising, bleeding, swelling, scabs, infection, blood clots in veins and lungs, hemorrhage, allergic reactions, skin pigmentation change, itching, pain, bruising, skin darkening, skin lightening, blistering, crusting, increased hair growth, loss of hair, muscle damage and even death.

I understand that the instructions that must be followed before, during and after the treatment or therapy will be explained to me. I agree to follow all of those instructions. I understand that medications may have adverse effects. I agree to read and follow the directions and agree to understand the possible side effects provided by the manufacturer and report any problems to my Provider.

I certify that I have read, or have had read to me, and understand the above contents. Where I had any questions, about any of the above, explanations have been provided to me.

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Patient Signature/Print Name Date/Time

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Witness Guardian Interpreter (if required)

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For the Procedure listed below, the desired effect and nature of the procedure to be performed, the risks involved and potential undesirable outcomes, as well as possible alternative methods of treatment have been fully explained to me and I consent to the performance of this procedure.

Procedure:____

I agree that I have been provided an information sheet about this procedure.

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Patient Signature/Print Name Date/Time

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Witness Guardian Interpreter (if required)

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For the Procedure listed below, the desired effect and nature of the procedure to be performed, the risks involved and potential undesirable outcomes, as well as possible alternative methods of treatment have been fully explained to me and I consent to the performance of this procedure.

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I agree that I have been provided an information sheet about this procedure.

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Patient Signature/Print Name Date/Time

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Patient Signature/Print Name Date/Time

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Witness Guardian Interpreter (if required)