SkinMD®
BELLE MEADE | NASHVILLE

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Informed Consent for Surgical Procedures

I give my permission for the Doctors and staff of *SkinMD* to treat me, including any biopsy, electrodesiccation and curettage (ED&C), excision, or procedure(s), as deemed necessary in the exercise of their professional judgment.

MEDICAL SURGICAL PROCEDURES

______ I understand that medical care requires my cooperation, and I will follow my doctor's orders and prescriptions. If indicated, I will make and keep appointments for follow-up care and call the office to note any changes or concerns in my condition.

______ I authorize my physician and *SkinMD* to take photographs/video tape or by other similar means record my surgery/procedure(s) and that every effort will be made to protect my identity in those materials.

______ I **DO / DO NOT** authorize the reproduction or publication of said photographs and recordings for the purpose of:

☐ education ☐ marketing/social media

☐ before and after surgical portfolios and/or documentation for my medical record

______ I further acknowledge that all recorded media obtained is the sole property of *SkinMD*.

______ I have been informed, to my satisfaction, regarding the nature of the procedure and why it is necessary.

______ I have been informed, to my satisfaction, regarding the risks inherent to the performance of any surgical procedure such as loss of blood, infection, reaction to anesthesia, hematoma formation, tingling, numbness or other nerve damage, formation of thick or otherwise objectionable scars, or recurrence. I realize that such, or any, natural complications may result from the surgical procedure.

______ I give permission to have any tissue(s) removed during this procedure to be disposed of properly or sent for histologic examination by a pathologist.

COSMETIC SURGICAL PROCEDURES

______ I understand that if my procedure is deemed "cosmetic or elective" in nature, that the charges WILL NOT be filled with my insurance by the provider or myself. I understand that payment for such services is due on the date that they are provided. I understand that I will also be responsible for any applicable co-pays, co-insurance or deductibles if I also receive an office visit today.

____ ____________
Patient Name (Print) Date

____ ____________
Signature of patient or patient's legal guardian/witness Date

____ ____________
MD Signature Date

Informed Consent for Surgical Procedures

My signature on this form authorizes Dr.Jacobson or her authorized PA/NP (Physician Assistant/Nurse Practitioner) to perform the following procedure(s):
☐ **Punch/Shave Biopsy** ☐ **Excision** ☐ **Electrodessication and Curettage (ED&C)** ☐ **Cryotherapy**
☐ **Incision and Drainage** ☐ **Intramuscular Steroids** ☐ **Intralesional Steroid Injection**
☐ **Cosmetic Shave Removal** ☐ **Cosmetic Skin Tag Removal** ☐ **Cosmetic Punch Excision** ☐ **Other __________________________**

____ _____________
Patient Name (Print) Date

____ _____________
Signature of patient or patient's legal guardian/witness Date

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☐ **Cosmetic Shave Removal** ☐ **Cosmetic Skin Tag Removal** ☐ **Cosmetic Punch Excision** ☐ **Other __________________________**

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____ _____________
Patient Name (Print) Date

____ _____________
Signature of patient or patient's legal guardian/witness Date

Patient Name: ____________________________ New/Established Date: _______________ DOB: ______________________