CONSENT FORMS

CONSENT – SKIN BIOPSY

To the patient: You have the right to be informed about your skin condition and treatment and to decide whether or not to undergo the procedure(s) after knowing the risks and hazards involved. This disclosure is not meant to frighten or alarm you in any way; it is simply an effort to better inform you so that you may give or withhold your consent for the treatment program.

I have been informed by my provider **Name of Provider**, of all the risks, benefits and alternative treatments concerning a skin biopsy. I understand that biopsies may be needed for assisting in the diagnosis of my condition. A biopsy is a surgical procedure used to obtain a sample of tissue for microscopic examination to aid the physician in my diagnosis. The entire lesion may not be removed during this procedure. I am also aware that this biopsy may not yield a specific diagnosis and may have results that are not specific. Not having a biopsy done may make it more difficult for my provider to diagnose my condition and delay appropriate treatment. Further medical or surgical treatment may be needed when the diagnosis is made.

I understand that **discoloration** (skin appearing lighter or darker in color); **scarring**, **hypertrophic/keloid scarring** (raised and thick scars which may be symptomatic with itching/burning/pain), **reaction to anesthesia**, **pain**, nerve damage, loss of sensation, blood loss, or infections are possible risks/complications from this treatment. I realize that these and other natural complications may result from the procedure. Other possible risks include incomplete removal, recurrence and poor results. There will be scarring with each and every biopsy procedure.

I understand that there is a slight possibility of an allergic reaction to any medications administered which may range from mild to potentially life threatening. I consent to administration of local anesthesia to be applied by or under the direction and supervision of the provider listed above. **I have no known allergies to Lidocaine (Xylocaine) &/or Epinephrine.**
I understand the wound care instructions given to me (written and verbal) and will apply topical antibiotics for my wound care. Biopsy sites are subject to bleeding and I will notify my provider of any excessive bleeding. I will notify my provider of any medications that affect my coagulation (rate of blood clotting).

I give my permission to release any tissue specimens to an appropriate facility for microscopic evaluation. I understand that my insurance plan may require the doctor/provider to send the tissue to a laboratory whose pathologists are not Board Certified Dermatopathologists. In such cases it is agreed that my physician/provider will not be liable for any error in the laboratory pathology interpretation. I understand that the pathology laboratory is a different entity than this doctors office and am aware of the risk for lost specimens, delayed diagnosis, and misdiagnosis by the laboratory. I understand that there may be a separate bill from the pathology laboratory.

I consent to be photographed before or after the treatment, and that these photographs shall be the property of the above provider and may be published for scientific journals and/or shown for educational reasons.
I agree to cooperate with my provider after this procedure and will notify my provider of any address changes or complications from procedures until I have been completely discharged from their care. I understand that is it not possible to guarantee or give assurance of a successful result. I have been given opportunity to ask questions about this procedure. I am aware that this consent form is also posted and can also be reviewed on the office website : www.Islanddermatology.net

The nature, purpose, and possible complications have been clearly explained to me to my satisfaction. I understand the explanation that I have received including my right to refuse such treatment. I have read this form, have discussed it with my physician and I understand it. After carefully reviewing the above paragraphs, I hereby consent to the biopsy.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING.

CONSENT – SURGICAL EXCISION

To the patient: You have the right to be informed about your skin condition and treatment to decide whether or not to undergo the procedure(s) after knowing the risks and hazards involved. This disclosure is not meant to frighten or alarm you in any way; it is simply an effort to better inform you so that you may give or withhold your consent for the treatment program.

I have been informed by my provider **Name of Provider** of all the risks, benefits and alternative treatments concerning a surgical excision. Surgical excision is a common treatment of removing with margins of certain lesions including but not limited to the following : benign growth such as cysts; abnormal moles such as dysplastic nevi; skin cancers such as basal cell carcinoma, squamous cell carcinoma or malignant melanoma.

The benefits and risks of outpatient surgery have been explained to me as well as the procedure which will be performed on me. I have been informed and understand the risks inherent to the performance of any surgical procedure such as **bleeding, infection, reaction to anesthesia, numbness and/or lack of sensation, nerve damage** that can result in temporary or rarely permanent paralysis of the associated muscle, and in rare cases, **abnormal scars** may result. **Scars may be thick (hypertrophic/keloid)**, unattractive, and a different color than the surrounding skin. These thickened scars may be symptomatic (itchy/burning/painful). There is possibility of visible marks from sutures used to close the wound. These can be a temporary or permanent outcome. I have been advised that there also may be a possibility of the **wound opening up (dehiscence)** due to increased pull on the wound and have been advised avoid heavy lifting and/or exercise for at least 2 weeks. I also understand that during the operation, unforeseen conditions may be revealed that necessitates an extension of the original procedure(s) or different procedure(s) than those planned. The possibility of plastic surgery at a later time has been discussed. I release the doctor from any responsibility which takes place as a natural complication of the procedure. There is the possibility of a poor result form surgical excision and may result in unacceptable visible deformities, loss of function, wound and loss of sensation.

Alternative forms of management including liquid nitrogen freezing, topical medication, curette (scraping), plastic surgery and radiation if appropriate for this skin lesion have been discussed. Risks and benefits of not treating this skin lesions have also been discussed which include potential for continual growth, progression to more aggressive form, local spread, disfigurement, spread to other distant sites (metastasis) and in rare cases being fatal. In rare situations, skin lesions (benign or malignant/cancerous) can recur (return at a later time) after surgical excision. Additional treatment or secondary surgery may be necessary in these instances.

I understand that there is a slight possibility of an allergic reaction to any medications administered which may range from mild to potentially life threatening. I consent to administration of local anesthesia to be applied by or under the direction and supervision of the provider listed above. **I have no known allergies to Lidocaine (Xylocaine) &/or Epinephrine.** I understand the wound care instructions given to me (written and verbal) and will apply topical antibiotics for my wound care. Surgical sites are subject to bleeding and I will notify my provider of any excessive bleeding. I will notify my provider of any medications that affect my coagulation (rate of blood clotting).

I give my permission to release any tissue specimens to an appropriate facility for microscopic evaluation. I understand that my insurance plan may require the doctor/provider to send the tissue to a laboratory whose pathologists are not Board Certified Dermatopathologists. In such cases it is agreed that my physician/provider will not be liable for any error in the laboratory pathology interpretation. I understand that the pathology laboratory is a different entity than this doctors office and am aware of the risk for lost specimens, delayed diagnosis, and misdiagnosis by the laboratory. I understand that there may be a separate bill from the pathology laboratory.

I realize it is my responsibility to keep postoperative appointments, cooperate with the provider regarding my care until completely discharged, and keep the above doctor and/or his associates informed of any change of address or telephone number so that they can notify me of the any late findings. If I feel any problems exist such as bleeding, infection or if I have any doubts, I am to contact the doctor as soon as possible. I am aware that this consent form is also posted and can also be reviewed on the office website : www.Islanddermatology.net

I have also been given opportunity to ask questions about this procedure. Additionally, I acknowledge that the doctor has made no promises to me, oral or written, in connection with the surgery. I recognize that every surgical procedure involves uncertainty and that no result can ever be guaranteed. I have also been advised that I may be disappointed with the result of this surgery.

The nature, purpose, and possible complications have been clearly explained to me to my satisfaction. I understand the explanation that I have received including my right to refuse such treatment. I have read this form, have discussed it with my physician and I understand it. After carefully reviewing the above paragraphs, I hereby consent to this surgical treatment.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING.

CONSENT – MOHS SURGERY

To the patient: You have the right to be informed about your skin condition and treatment to decide whether or not to undergo the procedure(s) after knowing the risks and hazards involved. This disclosure is not meant to frighten or alarm you in any way; it is simply an effort to better inform you so that you may give or withhold your consent for the treatment program.

I have been informed by my provider **Name of Provider** , of all the risks, benefits and alternative treatments concerning a Mohs Micrographic Surgery for the treatment of my skin cancer. Mohs Micrographic Surgery steps involve: use of local anesthetic the obvious cancer is removed with a scalpel. A layer of tissue below the obvious cancer is also removed and examined under a microscope. If the cancer is present in this first layer, a second layer is taken, and so on, until the excised tissue is free of cancer.

I have been informed and understand the risks inherent to the performance of this procedure, such as: **Large wound** (however, smallest possible to remove entire cancer); possible need for additional **surgery to cover or close the wound**; temporary (rarely permanent) **numbness** to the skin surrounding the wound; **nerve damage and loss of function to muscle near the wound which may be permanent** (most common when cancer involves areas near the temple, jaw or back of neck; **infection and/or bleeding** can occur after any surgical procedure; **scars** that may be thick (keloid), unattractive, or a different color than the surrounding skin (can be a temporary or permanent outcome); possibility of visible marks from sutures used to close the wound; possible need for **additional surgery or radiation therapy** to remove all of the cancer if it has invaded deeper structures such as bones or nerves; **recurrence of the cancer** (the chance of skin cancer reappearing at later time); **wound opening up (dehiscence)** due to increased pull on the wound and am advised avoid heavy lifting and/or exercise for at least 2 weeks.

I understand that there is a possibility of an allergic reaction to any medications administered which may range from mild to potentially life threatening. I consent to administration of local anesthesia to be applied by or under the direction and supervision of the provider listed above. **I have no known allergies to Lidocaine (Xylocaine) &/or Epinephrine.** I am not known to be **allergic** to anything except_____ (If no exceptions, report "none").

Alternative forms of management including liquid nitrogen freezing, topical medication, curettage (scarping), plastic surgery and radiation if appropriate for this skin lesion have been discussed. Risks to my health and benefits of not treating this skin cancer have also been discussed, which include potential for continual growth, progression to more aggressive form, local spread, disfigurement, spread to other distant sites (metastasis) and in rare cases being fatal. In rare situations, skin the skin cancer can recur (return at a later time) after surgical excision. Additional treatment or surgery may be necessary in these instances. I recognize that, during the course of the surgery, unforeseen conditions may necessitate additional or different procedures than those set forth above. I also understand transfer of care to a Plastic Surgeon or admission to a hospital might be advised after the procedure. I agree to admission to a hospital if in the performing surgeon's opinion such admission would be advisable. I consent to be photographed before or after the treatment, and that these photographs shall be the property of the above provider and may be published for scientific journals and/or shown for educational reasons.

My questions concerning the surgical procedure have been answered to my satisfaction. I give my consent for the above doctor/surgeon/provider and his/her assistant who may be a physician assistant or medical resident to perform this procedure. 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 as to the results of the surgical procedure. I realize it is my responsibility to keep postoperative appointments, cooperate with the provider regarding my care until completely discharged, and keep the provider informed of any change of address so that they can notify me of any late findings. I am aware that this consent form is also posted and can also be reviewed on the office website : www.Islanddermatology.net

The nature, purpose, and possible complications have been clearly explained to me to my satisfaction. I understand the explanation that I have received including my right to refuse such treatment. I have read this form, have discussed it with my physician and I understand it. After carefully reviewing the above paragraphs, I hereby consent to this surgical treatment.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING.

CONSENT – CORTISONE/STEROID INJECTION

To the patient: You have the right to be informed about your skin condition and treatment and to decide whether or not to undergo the procedure(s) after knowing the risks and hazards involved. This disclosure is not meant to frighten or alarm you in any way; it is simply an effort to better inform you so that you may give or withhold your consent for the treatment program.

I have been informed by my provider **Name of Provider**, of all the risks, benefits and alternative treatments concerning a cortisone or steroid injection. Intra-muscular steroid injection involves a corticosteroid called triamcinolone acetonide which is injected into a muscle for systemic therapeutic effect. Intra-lesional steroid injection involves a corticosteroid called triamcinolone acetonide which is injected directly into lesion or immediately below the skin for local therapeutic effect.

INTRA-MUSCULAR INJECTION - INJECTION INTO MUSCLE

I understand the following potential side effects: **pain at injection site, bruising of the skin**, **avascular necrosis of bone**, **elevated blood sugar** (temporary), **increased appetite and weight gain** (temporary), **menstrual irregularities, adrenal suppression**, **atrophy of the surrounding fatty tissue**, with temporary and rarely permanent **depression of skin at the injection site.**

INTRA-LESIONAL INJECTION - INJECTION DIRECTLY INTO OR BELOW SKIN LESION

I understand the following potential side effects which may be temporary and rarely permanent: **depression of the skin** at the injection site, **discoloration** (either lightening or darkening) of the skin, scarring, thinning of the surrounding fatty tissue.

I am not known to be allergic to corticosteroids. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as the results of this injection.

Alternative forms of management including topical medication, systemic medication, surgery and having no treatment at all, if appropriate for this skin lesion have been discussed. Additionally, I acknowledge that the doctor has made no promises to me, oral or written, in connection with the surgery. I recognize that this procedure involves uncertainty and that no result can ever be guaranteed. I have been given an opportunity to ask any questions and that my provider has explained to me the risks and hazards involved. I am aware that this consent form is also posted and can also be reviewed on the office website : www.Islanddermatology.net

The nature, purpose, and possible complications have been clearly explained to me to my satisfaction. I understand the explanation that I have received including my right to refuse such treatment. I have read this form, have discussed it with my physician and I understand it. After carefully reviewing the above paragraphs, I hereby consent to the cortisone/steroid injection.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING.

CONSENT – CANTHERONE/CANTHACUR

To the patient: You have the right to be informed about your skin condition and treatment and to decide whether or not to undergo the procedure(s) after knowing the risks and hazards involved. This disclosure is not meant to frighten or alarm you in any way; it is simply an effort to better inform you so that you may give or withhold your consent for the treatment program.

I have been informed by my provider **Name of Provider**, of all the risks, benefits and alternative treatments concerning cantherone/canthacur treatment. Cantherone also known as "beetle juice" is a solution used in the treatment of Molluscum Contagious and Common Warts.

I understand that **discoloration** (skin appearing lighter or darker in color); permanent **scarring**, **pain**, nerve damage, loss of sensation, bleeding, or infections are possible complications from this treatments. I realize that these and other natural complications may result from the procedure. Other possible risks include incomplete removal, recurrence**, increased size (annular/ring warts),** nail damage and poor results.

All risk, benefits and alternatives to this treatment have been explained to me. Alternatives include liquid nitrogen freezing, topical prescription and/or over the counter medications and watchful waiting (no treatment). I understand that not treating these lesions should also be considered as Molluscum Contagiosum and most Common Warts may be reversible and resolve on their own in months to many years.

I understand the treatment should be left covered for _____**min / hour** and then gently washed with soap and water.

If stinging, burning or tenderness occurs, I have been instructed to remove the bandage as soon as possible and wash with soap and water. I understand that a **BLISTER** may form at the treatment site within 12 hours. I understand the wound care instructions given to me and will apply topical antibiotics for my wound care. I agree to cooperate with my provider after this procedure and will notify my provider of any address changes or complications from procedures until I have been completely discharged from their care.

I understand that there is no guarantee that this treatment will work and also will most likely need to have many and multiple treatments and visit. I have been given an opportunity to ask any questions and that my provider has explained to me the risks and hazards involved. I am aware that this consent form is also posted and can also be reviewed on the office website : www.Islanddermatology.net

The nature, purpose, and possible complications have been clearly explained to me to my satisfaction. I understand the explanation that I have received including my right to refuse such treatment. I have read this form, have discussed it with my physician and I understand it. After carefully reviewing the above paragraphs, I hereby consent to the cantherone treatment.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING.

CONSENT – PREDNISONE/STEROIDS

To the patient: You have the right to be informed about your skin condition and treatment and to decide whether or not to undergo the procedure(s) after knowing the risks and hazards involved. This disclosure is not meant to frighten or alarm you in any way; it is simply an effort to better inform you so that you may give or withhold your consent for the treatment program.

I have been informed by my provider **Name of Provider**, of all the risks, benefits and alternative treatments concerning a prednisone (systemic steroids). Because of the severity or extent of your disease your provider feels that prednisone/corticosteroids are indicated as part of your treatment.
Alternatives: continuing to try to manage your disease with non-steroidal medications.
Risks: Costicosteroids (also known as "cortisone," "steroids," and "prednisone.") may be associated with development of side effects, some of which can be serious. The more common risks include:

- Thinning of bones **(osteoporosis)** which may lead to **fractures or compressions**, especially true of vertebral bodies (backbone)
- Loss of blood supply to bones **(aseptic necrosis)** which may cause severe bone pain, fractures (especially of the hip and shoulder) and may require surgical correction
- **Elevations in blood sugar (diabetes)**
- **High blood pressure** (hypertension)
- Increased pressure in the eye **(glaucoma)** . Permanent clouding of vision in one or both eyes **(cataracts)**
- Weight gain with increased appetite and fluid retention. Facial fullness
- Increase in body hair and acne and tendency to easy bruising and thinning of the skin
- Increased risk of infections
- **Interference with growth**
- Muscle cramps and joint pain
- Changes in menstrual cycle
- Suppression of your own body's adrenal glands ability to make necessary cortisone at times of stress
- Emotional disturbances

I have read and fully understand this consent form, and I consent to allow my physician to treat me with corticosteroids. I understand that I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand the terms or words contained in this consent form. I am aware that this consent form is also posted and can also be reviewed on website : www.Islanddermatology.net

The nature, purpose, and possible complications have been clearly explained to me to my satisfaction. I understand the explanation that I have received including my right to refuse such treatment. I have read this form, have discussed it with my physician and I understand it. After carefully reviewing the above paragraphs, I hereby consent to the prednisone (systemic steroids).

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING.

CONSENT – BOTOX

To the patient: You have the right to be informed about your skin condition and treatment and to decide whether or not to undergo the procedure(s) after knowing the risks and hazards involved. This disclosure is not meant to frighten or alarm you in any way; it is simply an effort to better inform you so that you may give or withhold your consent for the treatment program.

I have been advised that the object of the procedure I have requested is improvement in appearance, not perfection. It is possible for imperfections to ensue, and that the result may not live up to my expectations or goals. I acknowledge that no written or implied verbal guarantee, warranty or assurance has been made to me regarding the outcome of the procedure which I have requested and authorized. I also understand the limitations of this procedure.

I have been informed by my provider **Name of Provider**, of all the risks, benefits and alternative treatments concerning Botox therapy. This is the trademark for botulinum toxin. Injections of Botox are known to weaken the facial muscles, which cause frowning, crow's feet and forehead lines of expression. This use is termed unlabeled or off-label use; that is, it has been used for wrinkles after it was originally approved for eye disorders. Botox is also use to treat hyperhidrosis (excessive sweating in the underarms and palms(hands)/soles(feet). This is considered "innovative" therapy. Known significant risks have been disclosed in this form, yet the theoretical risk of unknown complications does exist.

When used for **FACIAL WRINKLES**, the Botox solution is injected into the muscle with a small needle. The benefits of the injection develop over the next five to seven days (occasionally longer). Typically, the muscle action (and wrinkles) will return in 3-5 months. Botox is best at treating dynamic facial lines, those caused by facial muscle activity. Lines present at rest may or may not improve. When used for **HYPERHIDROSIS**, the Botox solution is injected into both axilla (arm pits) and/or directly into the palms or soles of feet. Excess odor (smell) caused by hyperhidrosis will not improve. Typical results last for about 6 months.

Side effects and complications include **headache, pain** during and after injection, **asymmetry** (one side different than the other), loss of facial expression when attempting to show emotions, twitching and numbness. Occasionally, slight swelling and/or **bruising** may occur which can last for several days or weeks after injection. Botox may rarely diffuse/migrate or be injected in an adjacent muscle which may be weakened and cause **drooping** of the eyelid(s) and/or drooping of one or both eyebrows may occur. I have been advised of other risks involved in such treatment and alternative treatments, including no treatment at all. I will do facial exercises and not recline for at least 4 hours. No massages today. I am not pregnant, not trying to get pregnant and to the best of my knowledge nor do I have any significant neurological disease. I have no history of myasthenia gravis (a neurologic disorder); I have no allergy to Albumin; I am not currently taking any aminoglycoside antibiotics. Although the results are usually dramatic, I have been informed that the practice of medicine is not an exact science and that no guarantees can be, nor have been, made to me concerning expected results in my case. I have been given an opportunity to ask any questions and that my provider has explained to me the risks and hazards involved. This procedure is cosmetic in nature and I understand that payment will be my responsibility. I understand that several visits and sessions may be needed to complete the injection series. I am aware that this consent form is also posted and can also be reviewed on the office website : www.Islanddermatology.net

The nature, purpose, and possible complications have been clearly explained to me to my satisfaction. I understand the explanation that I have received including my right to refuse such treatment. I have read this form, have discussed it with my physician and I understand it. After carefully reviewing the above paragraphs, I hereby consent to the Botox therapy.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING.

CONSENT – FILLER

To the patient: You have the right to be informed about your skin condition and treatment and to decide whether or not to undergo the procedure(s) after knowing the risks and hazards involved. This disclosure is not meant to frighten or alarm you in any way; it is simply an effort to better inform you so that you may give or withhold your consent for the treatment program.

I have been advised that the object of the procedure I have requested is improvement in appearance, not perfection. It is possible for imperfections to ensue, and that the result may not live up to my expectations or goals. I acknowledge that no written or implied verbal guarantee, warranty or assurance has been made to me regarding the outcome of the procedure which I have requested and authorized. I also understand the limitations of this procedure. I should not receive this treatment if I have unattainable expectations. I agree to not hold Island Dermatology responsible for the treatment not meeting my expectations. I understand that several sessions may be needed for best results.

I have been informed by my provider **Name of Provider**, of all the risks, benefits and alternative treatments concerning a fillers.

Fillers (**Restylane/Perlane/Juvederm**) are sterile gel consisting of non-animal stabilized hyaluronic acid for injection into the skin to correct facial lines, wrinkles, folds and to enhance the appearance and fullness of the lips.

SIDE EFFECTS / COMPLICATIONS
As with any medical procedure you should be aware of the risks associated with this treatment. Please initial your understanding and consent to the following statements:

_____ **Bleeding / Bruising** – this risk is usually temporary and resolves in weeks although very rarely may leave permanent staining. If hematoma occurs (collection of blood under the skin) it may require emergency treatment or surgery. The following may contribute to a greater risk of bleeding and should be stopped 1 week prior and 1 week after this treatment : Alcohol, aspirin, ibuprofen, platelet inhibitors, anticoagulants (Coumadin/Heparin), Vitamin E, Ginkgo Biloba, Ginger, Ginseng, Garlic, Fish oils, Saw Palmetto & St Johns Wort. **Swelling** – Swelling is a normal occurrence following the injections. It decreases after a few days. If swelling is slow to resolve, medical treatment may be necessary. **Pain** – Discomfort associated with injections is normal and usually of short duration. Damage to deeper structure such as nerves may result with temporary or permanent pain and loss of function.

_____ **Infection** – Bacterial, mycobacteria, fungal and viral injections can occur. These injections may need treatment with antibiotics for a short or prolonged period of time. **Herpes Viral Infection** – Injection around the mouth can occur following a tissue filler injection. This applies to both individuals with a past history of Herpes simplex virus and individuals with no known history of Herpes simplex virus infection in the mouth area. Please make your provider aware if you do have a history of previous Herpes simplex virus infection so specific medication can be prescribed and taken both prior to and following the treatment procedure in order to suppress an infection flare.

Island Dermatology Inc.
FILLER (Restylane / Perlane / Juvederm) CONSENT
(continued from page 1)

_____ **Lumpiness** – lumpiness can occur following injection of fillers. It tends to smooth out over time. In some situations, it may be possible to feel the injected tissue filler material for long periods of time. **Granulomas** – Painful masses in the skin and deeper tissue after a filler injection are rare. Should these occur, additional treatments including surgery may be necessary.

_____ **Allergic reactions / Hypersensitivity** – As with all biologic products, local allergic and systemic anaphylactic reactions may occur.

_____ **Intra-arterial injection and blockage** – It is extremely rare that during the course of injection, filler material could be accidentally injected into or adjacent to arterial structures and produce a blockage of blood flow. This may produce **skin necrosis/ulcers, permanent vision loss or even a stroke.** Skin necrosis can produce unacceptable scarring. Should this complication occur, additional treatments, or surgery may be necessary.

_____ **Discoloration / Scarring** - There are risks of discoloration at injection site, which typically resolves in weeks or months but may be permanent. Filler can very rarely cause hypertrophic scar or keloid formation specially in those with a previous history. A history of keloid formation is not necessary an indication of a new keloid due to this injection.

_____ I should not receive this treatment if I have **unattainable expectations.** I agree to not hold Island Dermatology responsible for the treatment not meeting my expectations. I agree and understand that this treatment is an elective procedure for cosmetic purposes only, it is not medically necessary and payment for the procedure will be made in full prior to treatment.

I am aware that this consent form is also posted and can also be reviewed on the office website : www.Islanddermatology.net

The nature, purpose and possible complications have been clearly explained to me to my satisfaction. I understand the explanation that I have received including my right to refuse such treatment. I have been informed by my provider all the risks, benefits and alternative treatments concerning this procedure. I have read this form, have discussed it with my physician, have been given an opportunity to ask questions and I understand it. I agree to cooperate with my provider after this procedure and will notify my provider of any address changes or complications from procedures until I have been completely discharged from their care. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as the result of this procedure. After carefully reviewing the above paragraphs, I hereby consent to the Filler treatment.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING.

CONSENT – CHEMICAL PEEL

To the patient: You have the right to be informed about your skin condition and treatment and to decide whether or not to undergo the procedure(s) after knowing the risks and hazards involved. This disclosure is not meant to frighten or alarm you in any way; it is simply an effort to better inform you so that you may give or withhold your consent for the treatment program.

I have been advised that the object of the procedure I have requested is improvement in appearance, not perfection. It is possible for imperfections to ensue, and that the result may not live up to my expectations or goals. I acknowledge that no written or implied verbal guarantee, warranty or assurance has been made to me regarding the outcome of the procedure which I have requested and authorized. I also understand the limitations of this procedure.

I have been informed by my provider **Name of Provider**, of all the risks, benefits and alternative treatments concerning a chemical peel. The peel program was explained to me in detail. I understand that I can expect to have several minutes of stinging or burning sensations immediately after the medication has been applied. I understand that during healing from my peel, my skin will look discolored and shiny and that I may be unable to work. My particular peel and its relationship to my ability to work have been discussed with me. I also understand that I should refrain from waxing my skin for hair removal. Importance of sun avoidance and aggressive sun protection to enhance results and lower risk of scarring has been discussed with me at length. Prompt recognition and treatment of any complication is necessary to decrease its potential complications. Risk and complication of this procedure include : **Skin infections** – usually appearing as a red tender area, often with a scab ; **cold sore** on my lips or face; **prolonged sensitivity** to the wind and sun; **permanent scarring - persistent areas of increased or decreased pigmentation (white or brown areas)**

I have been advised that the object of the procedure I have requested is improvement in appearance, not perfection. It is possible for imperfections to ensue, and that the result may not live up to my expectations or goals. I acknowledge that no written or implied verbal guarantee, warranty or assurance has been made to me regarding the outcome of the procedure which I have requested and authorized. I also understand the limitations of this procedure. I should not receive this treatment if I have unattainable expectations. I agree to not hold my provider responsible for the treatment not meeting my expectations. I understand that several sessions may be needed for best results. I give consent to proceed with this treatment session and any subsequent treatment sessions. I agree and understand that this treatment is an elective procedure for cosmetic purposes only, it is not medically necessary and payment for the procedure will be made in full at the time of treatment. I am aware that this consent form is also posted and can also be reviewed on the office website : www.Islanddermatology.net

The nature, purpose and possible complications have been clearly explained to me to my satisfaction. I understand the explanation that I have received including my right to refuse such treatment. I have been informed by my provider all the risks, benefits and alternative treatments concerning this procedure. I have read this form, have discussed it with my physician, have been given an opportunity to ask questions and I understand it. I agree to cooperate with my provider after this procedure and will notify my provider of any address changes or complications from procedures until I have been completely discharged from their care. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as the result of this procedure. After carefully reviewing the above paragraphs, I hereby consent to the Chemical Peel treatment.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING.

CONSENT – SCLEROTHERAPY

To the patient: You have the right to be informed about your skin condition and treatment and to decide whether or not to undergo the procedure(s) after knowing the risks and hazards involved. This disclosure is not meant to frighten or alarm you in any way; it is simply an effort to better inform you so that you may give or withhold your consent for the treatment program.

I have been advised that the object of the procedure I have requested is improvement in appearance, not perfection. It is possible for imperfections to ensue, and that the result may not live up to my expectations or goals. I acknowledge that no written or implied verbal guarantee, warranty or assurance has been made to me regarding the outcome of the procedure which I have requested and authorized.

I have been informed by my provider **Name of Provider**, of all the risks, benefits and alternative treatments concerning Sclerotherapy – treatment of spider veins. I hereby consent to undergo sclerotherapy. This treatment consists of injecting small amounts of medication (Glycerin) into the small blood vessels. The medication will cause the blood vessels to seal off and be absorbed into the body. More than one treatment may be necessary for optimum results. Compression hose are needed for use immediately following treatment for 1-2 weeks to help maximize the treatment results. I can resume normal activities the same day as the treatment. I have been instructed to avoid airplane travel for 1 week as this will increase the risk of blood clots.

I understand, fully and completely, that the alternative treatments for my condition are to either receive no treatment, laser treatment, or have a stripping and ligation (a surgical procedure performed by most vascular surgeons.
I am aware that sclerotherapy involves risks. I have been informed of the following: **Pain** at injection site and **burning** that can last for minutes to hours; Bruising; Swelling and redness that may last weeks; **Pigmentation** (discoloration of the skin which may last 4-12 months and may even be permanent) ; Blisters at the site of injection which may open, become ulcerated, and may take as long as 1 to 2 months to slowly heal leaving a **scar**; Telangiectatic **Matting** – development of new tiny blood vessels in the treated area which usually resolves in 4-6 months but may be permanent. **Allergic reactions**- rarely, a patient may have an allergic reaction to the treatment used which can potentially be fatal if not treated; Infection at injection site; **Phlebitis** and rarely **blood clots** in the veins which can lead to pulmonary embolism (clot in the lungs) and brain stroke. The risk of blood clots increases with smoking, hormone therapy, rheumatologic disease and underlying cancer; I have notified my provider if I have any of these stated risk factors.

With full knowledge of the benefits, risks, and alternative treatments, I consent to receive sclerotherapy by injection. I have had my questions answered to my satisfaction. Treatment of spider veins is a cosmetic procedure. I understand, fully and completely, that the alternative treatments for my condition are to either receive no treatment, laser treatment, or have a stripping and ligation (a surgical procedure performed by most vascular surgeons. It is understood that payment is due on the day of treatment. I am aware that this consent form is also posted and can also be reviewed on the office website : www.Islanddermatology.net

The nature, purpose and possible complications have been clearly explained to me to my satisfaction. I understand the explanation received including my right to refuse such treatment. I have been informed by my provider all the risks, benefits and alternative treatments with this procedure. I have read this form, have discussed it with my provider, have been given an opportunity to ask questions and I understand it. I am aware that the practice of medicine is not an exact science, and that no guarantees have been made to me as the result of this procedure. After carefully reviewing the above paragraphs, I hereby consent to Sclerotherapy.

ISLAND DERMATOLOGY – INFORMED CONSENT

LATISSE – FDA APPROVED

I, _____, understand that I will be given a prescription for Latisse (bimotoprost ophthalmic solution) which is indicated to treat hypotrichosis (inadequate or not enough length) of the eyelashes by increasing their growth, thickness, darkness, and length.

_____ **I am not allergic** to Latisse (bimotropost)

_____ **I am not pregnant**, trying to get pregnant or breastfeeding and will discontinue use if I become pregnant

_____ I understand there is a **risk of itching, hyperpigmentation of the skin, irritation, dry eyes, redness, infection and allergic reaction**

_____ I understand that increased iris (colored part of eye) pigmentation may occur. **Potential for brown iris pigmentation** is likely to be permanent and may not be noticeable for several months to years

_____ I understand that this product has been reported to cause pigment darkening of the eyelid. This side effect has been reported to be reversible upon the discontinuation of treatment

_____ I do not have chronic eye problems (ie Glaucoma) and will notify my doctor that I am using Latisse before any eye exams or procedures

_____ I understand that Latisse must be used exactly as directed to reduce risk of side effects

1- Bottle must be kept intact during use
2- Place one drop on the single use per eye applicator
3- Bottle tip should never be allowed to contact any other surface to avoid contamination
4- Sterile applicators may only be used on one eye and then discarded. Reuse of the applicators increases the potential for contamination and infection
5- Do not apply Latisse to bottom lashes
6- Do not use Latisse more than once per day. Additional application will not increase results but will increase the risk of side effects

_____ I understand that after purchase, this product is **non-refundable**

By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. I hereby release Island Dermatology and the doctor/provider prescribing Latisse from liability associated with this product.

Island Dermatology Inc. – CONSENT – Kybella

PATIENT NAME

_____

To the patient: You have the right to be informed about your skin condition and treatment and to decide whether or not to undergo the procedure(s) after knowing the risks and hazards involved. This disclosure is not meant to frighten or alarm you in any way; it is simply an effort to better inform you so that you may give or withhold your consent for the treatment program.

I have been advised that the object of the procedure I have requested is improvement in appearance, not perfection. It is possible for imperfections to ensue, and that the result may not live up to my expectations or goals. I acknowledge that no written or implied verbal guarantee, warranty or assurance has been made to me regarding the outcome of the procedure which I have requested and authorized. I also understand the limitations of this procedure.

KYBELLA™ (deoxycholic acid) injection is indicated for improvement in the appearance of moderate to severe convexity or fullness associated with submental fat, also called "double chin," in adults. The safe and effective use of KYBELLA™ for the treatment of subcutaneous fat outside the submental region has not been established and is not recommended.

KYBELLA™ is injected into the fat under the chin. KYBELLA™ injections will be given at least 1 month apart.

RISKS OF KYBELLA™ INJECTIONS:

Every injection of a drug involves a certain amount of risk. Below are risks reported during clinical studies that are specific to the injection of KYBELLA™.

• KYBELLA™ injections commonly cause **swelling, bruising, pain, numbness, redness, and areas of hardness in the treatment area.** KYBELLA injections can also cause tingling, nodules, itching, skin tightness, and headache. These side effects typically resolve without treatment and do not commonly result in patients discontinuing treatment.

• Other less common potential side effects include:

o Nerve injury: KYBELLA™ injections could cause nerve injury in the area of the jaw resulting in an uneven smile or facial muscle weakness.

o Swallowing: KYBELLA™ injections can temporarily cause trouble with swallowing.

o Skin Ulceration: KYBELLA™ injections could cause superficial skin erosions which may lead to scarring.

o Alopecia; KYBELLA™ injections could cause small patches of alopecia in the treatment area.

o Unsatisfactory results: There is a possibility of an unsatisfactory result from injections of KYBELLA™. The procedure may result in unacceptable visible deformities or asymmetry in the treatment area.

BEFORE RECEIVING KYBELLA™ INJECTIONS:
KYBELLA™ should not be injected if there is an infection in the treatment area. Before receiving KYBELLA™, patients should tell their healthcare provider about all of their medical conditions, including if they:

- **have had or plan to have surgery on the face, neck, or chin**
- **have had cosmetic treatments on the face, neck, or chin**
- **have had or have medical conditions in or near the neck area**
- **have had or have trouble swallowing**
- **have bleeding problems or are taking blood thinners**
- **are pregnant or plan to become pregnant.**
- **are breastfeeding or plan to breastfeed.**

Patients should tell their healthcare provider about all the medicines they take, including prescription and over-the-counter medicines, vitamins, and herbal supplements. They should especially tell their healthcare provider if they take a medicine that prevents the clotting of blood (antiplatelet or anticoagulant medicine). Patients should be advised to inform their healthcare provider if they develop signs of marginal mandibular nerve paresis (e.g., asymmetric smile, facial muscle weakness), difficulty swallowing, or if any existing symptom worsens.

I am not pregnant or trying to become pregnant nor am I nursing at this time.

I release Island Dermatology Inc., Dr. Ellis ***(can insert other docs performing the procedure here)*** and all medical staff, from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

Although the results are usually dramatic, I have been informed that the practice of medicine is not an exact science and that no guarantees can be, nor have been, made to me concerning expected results in my case. I have been given an opportunity to ask any questions and that my provider has explained to me the risks and hazards involved. This procedure is cosmetic in nature and I understand that payment will be my responsibility. I understand that several visits and sessions may be needed to complete the injection series. I am aware that this consent form is also posted and can also be reviewed on the office website : www.Islanddermatology.net

The nature, purpose, and possible complications have been clearly explained to me to my satisfaction. I understand the explanation that I have received including my right to refuse such treatment. I have read this form, have discussed it with my physician and I understand it. After carefully reviewing the above paragraphs, I hereby consent to the Kybella therapy.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING.

PATIENT SIGNATURE _____ DATE _____ /_____/_____
(Or Signature of patient's legal guardian signifying informed consent)

WITNESS SIGNATURE _____ DATE _____ /_____/_____
(Or signature of person translating this form for patient)

Island Dermatology Inc. – CONSENT – PRP – Platelet Rich Plasma

PATIENT NAME _____

To the patient: You have the right to be informed about your skin condition and treatment and to decide whether or not to undergo the procedure(s) after knowing the risks and hazards involved. This disclosure is not meant to frighten or alarm you in any way; it is simply an effort to better inform you so that you may give or withhold your consent for the treatment program.

I have been advised that the object of the procedure I have requested is improvement in appearance, not perfection. It is possible for imperfections to ensue, and that the result may not live up to my expectations or goals. I acknowledge that no written or implied verbal guarantee, warranty or assurance has been made to me regarding the outcome of the procedure which I have requested and authorized. I also understand the limitations of this procedure.

I have been informed by my provider **Name of Provider** of all the risks, benefits and alternative treatments concerning Platelet Rich Plasma (PRP) therapy for Facial Rejuvenation and Hair Loss.

Platelet Rich Plasma (PRP) is an injection treatment that uses the components of a person's own blood to stimulate hair growth. Platelets are very small cells in your blood that are involved in the clotting process. When PRP is injected into the damaged area it causes a mild inflammation that triggers the healing cascade. As the platelets organize in the tissue they release a number of enzymes to promote healing, restoration of tissue and hair growth. A small quantity of blood is drawn from the patient into a syringe. The blood is spun in a special centrifuge to separate its components (Red Blood Cells, Platelet Rich Plasma, and Plasma). The platelet rich plasma is separated from the rest of the blood and then activated with a small amount of calcium to allow the release of growth factors from the platelets which in turn amplifies the restoration/rejuvenation and hair growth process. PRP is then either applied in conjunction with microneedling to the face/neck or injected directly into thinning areas of the scalp.

Relative Contraindications: Not a good candidate for this procedure
- Acute and chronic infections
- Certain skin diseases (i.e. SLE, porphyria)
- Allergies to anesthetics (Lidocaine, Xylocaine)
- Cancer / Chemotherapy
- Blood or bleeding disorders / Blood thinners / Anti-coagulation therapy
- Chronic liver disease
- Systemic use of corticosteroids within two weeks of the procedure
- Pregnant / Breast feeding

Risks and Complications of PRP:

- Temporary pinkness/rendess (flushing)
- Allergic reaction
- Pain / Itching at injection site
- Bleeding / Bruising / Swelling
- Nerve injury
- Nausea / Vomiting / Peri-operative dizziness or fainting

Use of local anesthetics may be used for your procedure if you are not allergic. Please initial if you have a problem with local anesthetics:

___ I am allergic ___ I am not sure ___ I am not allergic

Although the results are usually dramatic, I have been informed that the practice of medicine is not an exact science and that no guarantees can be, nor have been, made to me concerning expected results in my case. I have been given an opportunity to ask any questions and that my provider has explained to me the risks and hazards involved. This procedure is cosmetic in nature and I understand that payment will be my responsibility. I understand that several visits and sessions may be needed to complete the injection series. I am aware that this consent form is also posted and can also be reviewed on the office website : www.Islanddermatology.net

The nature, purpose, and possible complications have been clearly explained to me to my satisfaction. I understand the explanation that I have received including my right to refuse such treatment. I have read this form, have discussed it with my physician and I understand it. After carefully reviewing the above paragraphs, I hereby consent to the PRP Platelet Rich Plasma Therapy.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING.

PATIENT SIGNATURE _____ DATE _____ /_____/_____
(Or Signature of patient's legal guardian signifying informed consent)

WITNESS SIGNATURE _____ DATE _____ /_____/_____
(Or signature of person translating this form for patient)

Island Dermatology Inc. – CONSENT – Micro-Needling

PATIENT NAME _____

To the patient: You have the right to be informed about your skin condition and treatment and to decide whether or not to undergo the procedure(s) after knowing the risks and hazards involved. This disclosure is not meant to frighten or alarm you in any way; it is simply an effort to better inform you so that you may give or withhold your consent for the treatment program.

I have been advised that the object of the procedure I have requested is improvement in appearance, not perfection. It is possible for imperfections to ensue, and that the result may not live up to my expectations or goals. I acknowledge that no written or implied verbal guarantee, warranty or assurance has been made to me regarding the outcome of the procedure which I have requested and authorized. I also understand the limitations of this procedure.

I have been informed by my provider, **Provider Name** of all the risks, benefits and alternative treatments concerning Micro-needling – Collagen Inducting Therapy. The Skin Pen is a tool designed to stimulate your skin's natural ability to produce new collagen by creating micro-channels in the skin with the use of sterile, disposable needles. These needles penetrate the skin causing "injury", which stimulates new collagen. New collagen can improve fine lines and wrinkles, enhance skin tone and texture, improve acne scars and hyperpigmentation. Multiple treatments are needed for desired effect.

A series of 4 to 6 treatments are recommended and the frequency will depend on the intensity and depth of the needle.

I understand that there are some risks with any procedure. The following are possible reactions with Micro-needling: temporary bruising, skin discomfort during treatment, redness or swelling, lightening or darkening of the skin, itching and burning, lightening or darkening of skin, infection, scarring.

What to Expect:

- Depending on the area of your face or body being treated and the type of device used (i.e. needle length), the procedure is well-tolerated.
- Your practitioner will apply a topical anesthetic to your skin prior to treatment to reduce any pain and discomfort.
- Your skin will be pink or red in appearance, much like a sunburn, for a couple of hours following treatment.
- Minor bleeding and bruising is possible depending on the length of the needle used and the number of times it is pressed across the treatment area.
- Your skin may feel warm, tight, and itchy for a short while. This should subside in 12-48 hours.

Use of local anesthetics may be used for your procedure if you are not allergic. Please initial if you have a problem with local anesthetics:

___ I am allergic ___ I am not sure ___ I am not allergic

Side-Effects:

- Reddness / Flushing / Swelling / Discomfort / Bruising / Crusting / Infection
- Hyperpigmentation / Hypopigmentation / Permanent scarring
- Milia (small white bumps) may form; these can be removed by the practitioner.
- If you have a history of cold sores, this procedure may cause flare ups.

Micro-needling is not suitable in these circumstances. I will notify my provider if any of the following apply.

- Pregnancy / Breastfeeding
- Used Accutane (Isotretinoin) within the last year
- Active facial dermatitis – Rosacea / Eczema / Psoriasis
- Open wounds or abrasions on the skin. Active infections – viral / fungal / bacterial.
- Radiation treatment to the skin within the last year
- Herpes infection or history of herpes infection on the treatment area
- Have any history of keloid or hypertrophic scars or poor wound healing
- Immune-suppressed or Diabetes
- Wound healing deficiencies
- Bleeding disorder / Taking blood thinners

Although the results are usually dramatic, I have been informed that the practice of medicine is not an exact science and that no guarantees can be, nor have been, made to me concerning expected results in my case. I have been given an opportunity to ask any questions and that my provider has explained to me the risks and hazards involved. This procedure is cosmetic in nature and I understand that payment will be my responsibility. I understand that several visits and sessions may be needed to complete the injection series. I am aware that this consent form is also posted and can also be reviewed on the office website: www.Islanddermatology.net

The nature, purpose, and possible complications have been clearly explained to me to my satisfaction. I understand the explanation that I have received including my right to refuse such treatment. I have read this form, have discussed it with my physician and I understand it. After carefully reviewing the above paragraphs, I hereby consent to the Micro-needling.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING.

PATIENT SIGNATURE _____ DATE _____ /_____/_____
(Or Signature of patient's legal guardian signifying informed consent)

WITNESS SIGNATURE _____ DATE _____ /_____/_____
(Or signature of person translating this form for patie

Island Dermatology Inc. – CONSENT – PHOTODYNAMIC THERAPY (PDT)

LEVULAN / BLUE LIGHT TREATMENT

PATIENT NAME _____

LOCATION _____Face_____Scalp_____Upper Extremities_____

To the patient: You have the right to be informed about your skin condition and treatment to decide whether or not to undergo the procedure(s) after knowing the risks and hazards involved. This disclosure is not meant to frighten or alarm you in any way; it is simply an effort to better inform you so that you may give or withhold your consent for the treatment program.

I have been informed by my provider of all the risks, benefits and alternative treatments concerning Photo-Dynamic Therapy (PDT). Levulan is a photosensitizing compound, which is approved by the FDA to treat pre-cancerous skin lesions called actinic keratosis. Levulan is applied to the skin and subsequently "activated" by specific wavelength of blue light. This process is called Photodynamic Therapy.

I understand that Levulan will be applied to my skin and after the incubation time of 1 hour the area will be treated with a specific wavelength of blue light. I understand that I am not to leave the office building and go outside (avoid sunlight) for the 1-hour incubation period. The blue light treatment will last around 17 minutes during which time and especially in the first 7 minutes I will experience intense burning.

I understand that I should avoid direct sunlight for 48your following the treatment due to photosensitivity. I understand that any, even indirect sun exposure during this time can increase possible side effects including, **swelling, burning, blisters, redness and pain.**

Down time of this procedure, which includes peeling and redness may last few days to a few weeks. For any pain or discomfort after the treatment I may take Tylenol or ibuprofen unless I have a know reason (contraindication) to these over the counter medications. If my skin becomes dry and tight then moisturizing is important and achieved by applying Aquaphor or other over the counter moisturizer.

I have been strongly recommended to wear sunscreen/sunblock and a wide brim hat to cover by face and scalp. If the area treated is my upper extremities then I will also wear protective long sleeve clothing.

The benefits and risks of PDT have been explained to me as well as the procedure, which will be performed on me. I have been informed and understand the risks inherent to the performance of PDT including **pain, discomfort, skin pigment alteration, scabbing, blistering, activation of cold sores, telangiectasia (new small blood vessels) and rarely permanent scarring.**

Alternative forms of management including liquid nitrogen freezing, topical medication (creams), curette (scraping) and observation have all been explained to me. Risks and benefits of not treating this skin lesions have also been discussed which include potential progression of pre-skin cancer to skin cancer.

Y / N I have a condition that makes me sensitive to the sun

Y / N I have a photosensitizing medical diagnosis such as porphyria or lupus

Y / N I used Retina in that last week prior to procedure

Y / N I have used Antibiotics or any other photosensitizing medication in the last week

Y / N I have had a sunburn in the last week.

Y / N I have a history of facial cold sores (HSV – Herpes Simplex Virus)

Y / N I am pregnant o breastfeeding

Y / N I have any plans or events in the next 2 weeks (Vacation / Wedding / Birthday / Event)

I realize it is my responsibility to keep my follow-up appointments, cooperate with the provider regarding my care until completely discharged, and keep the above doctor and/or his associates informed of any change of address or telephone number so that they can notify me of the any late findings. If I feel any problems exist such as pain, infection or if I have any doubts, I am to contact the doctor as soon as possible. I am aware that this consent form is also posted and can also be reviewed on the office website : www.Islanddermatology.net

I have also been given opportunity to ask questions about this procedure. Additionally, I acknowledge that the doctor has made no promises to me, oral or written, in connection with the surgery. I recognize that every surgical procedure involves uncertainty and that no result can ever be guaranteed. I have also been advised that I may be disappointed with the result of this surgery.

The nature, purpose, and possible complications have been clearly explained to me to my satisfaction. I understand the explanation that I have received including my right to refuse such treatment. I have read this form, have discussed it with my physician and I understand it. After carefully reviewing the above paragraphs, I hereby consent to Photo-Dynamic Therapy (Levulan + Blue Light).

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING.

PATIENT SIGNATURE _____ **DATE** _____ /_____/_____
(Or Signature of patient's legal guardian signifying informed consent)

WITNESS SIGNATURE _____ **DATE** _____ /_____/_____
(Or signature of person translating this form for patient)