DERMATOLOGY EXPERTS

CONSENT TO TREATMENT

I hereby give my permission for Angelo E. Ayar M.D. P.A. (the Practice) to give me medical treatment.
I allow the Practice to file for benefits to pay for the care I receive.
I understand that:

- The Practice will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance
  I understand:

  I have the right to refuse any procedure of treatment.

  I have the right to refuse any procedure of treatment.

  I have the right to discuss all medical treatments with my provider.

  The most commonly encountered procedures in a Dermatology office are skin biopsies/cryotherapy/skin lesion removal/curettage/and administration of local anesthesia. Each procedure has a small risk of scarring the may or may not be noticeable (common), infection (uncommon), bleeding (rare), or allergic reaction (rare). I understand that a photographs image will be taken of any biopsy or surgery site performed to the sole purpose of identification of said site and insurance claims. I expressly consent to having said photograph taken **If you are allergic to any type of local anesthesia you much inform you provider immediately.**

  I understand that I may be billed by an outside laboratory for work that is preformed in this office, if my insurance company does not have a contracted lab or facility, or if services are not covered by my insurance company. I will notify the provider each time I have an appointment.

  In the event that my account must be turned over to a collection agency, I understand that a $15.00 collections fee will be added to my account.

  I hereby certify that I have read the foregoing CONSENT and fully understand the contents thereof.

  _____

  Signature of Patient of Legal Guardian