Treatment Consent and Expectations

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. This consent form is designed to obtain your permission to perform the evaluation necessary to identify the appropriate treatment for any identified condition(s). This includes but is not limited to biopsies, cryosurgery, injections and other treatments necessary to remove unwanted benign lesions.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at any office of West Michigan Dermatology. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services with a particular provider or our office.

You have the right to discuss the treatment plan with your provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding a test or treatment recommended by your health care provider, we encourage you to ask questions.

<u>This consent is being given voluntarily and encompasses the following:</u>

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner or Physician Assistant), and other health care designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I give permission to have any tissue (s) removed during the procedure to be sent for histological examination by a pathologist. I understand that at times further evaluation is required by a second pathologist. There will be a separate charge for pathology services within our office and if outside consultation is deemed appropriate.

I understand that if an additional procedure is recommended, such as a more invasive excision, Mohs surgery or other interventional procedures, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I authorize the release of information necessary to process my insurance claim and for payment to be made directly to WMD. I understand my copay is due with each visit. I agree to paying the portion of my care applied to my deductible or co-insurance when billed. If unable to pay in full, I will make payment arrangements with the billing department.

I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or personal representative **Date**