Treatment Consent Form

I hereby consent to have the treatment/operation described as:

____

Performed for the diagnosis described as:

____

I have been informed of the risks including, but not limited to: burns, scarring, skin discoloration, allergic reaction, infections, pain, limitation of movement. Possible alternative methods of treatment and possible consequences involved in treatment were also discussed.

I do hereby indemnify and hold harmless Chelsea Skin & Laser, its caregivers, staff, or any person involved in providing care who act in reliance upon this authorization.

Furthermore, I understand that medicine is not an exact science and the possibility exists that the treatment/operation may not have the benefits or results intended. I acknowledge that no guarantee has been made regarding the treatment/operation that I have authorized.

For **Cosmetic Removal Patients**:

Cosmetic Removals are not a covered service on any insurance plan.

- I understand that specimens removed, even if considered cosmetic in nature, may be sent to an outside lab for evaluation and I will receive a separate bill from the lab for their services. My specimen will be sent to a lab.
  Initial here ______

- I am choosing NOT to have the specimen that has been removed sent to a lab for evaluation.
  Initial here ______ **Not Applicable ______**

- As required by law, any medical conditions discussed and/or treated in the same visit as a cosmetic removal will be reported to my insurance company. I understand I am responsible for any charges as determined by my insurance company for medical issues discussed and/or treated as these are separate from cosmetic removal fees.
  Initial here ______

Understanding the above, I freely ask and authorize the treatment/operation.

____

Patient Name

______________________________________ ____________

Patient or Parent/ Legal Guardian Signature Date

PRINT and SIGN

AREAS NOTED IN RED ARE REQUIRED FIELDS

V 10-2015