BALSHI
BEAUTY. DERMATOLOGY. COSMETICS.

# DERMATOLOGY CONSENT

## TO THE PATIENT

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 your may make a decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I voluntarily request: My physician, the staff of Dr. Thomas Balshi, and such associates, technical assistants, and other health care providers as they deem necessary, to carry out the following procedure:

**General Dermatology procedures including but not limited to:**
**Biopsies, Skin checks, Injections, Excisions, Repairs, Removals, PRP, Amniofix, Hyperhydrosis, Laser Treatments**

I understand that no warranty or guarantee has been made to me as to result or care. I realize that, as in all medical treatment, complications or delay in recovery may occur which could lead to the need for additional treatment or surgery, and could also result in economic loss to me because of inability to return to normal activity as soon as anticipated. I understand that my physician may discover other or different conditions which may require additional or different procedures than those planned. I authorize him, and such associates, technical assistants, and other healthcare providers to perform such other procedures which are advisable in their professional judgment.

I understand that external incisions may leave scars that are visible. The locations of these incisions have been described to me. I realized that occasionally, scars may need to be revised because of unsatisfactory appearance.

Just as there may be risks and hazards in containing my present condition without treatment, there are also risks and hazards related to the performance of the surgical procedures planned for me.

I realize that common to surgical procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I also realize that the following risks and hazards may occur in connection, with this procedure: unsatisfactory appearance, poor healing, skin loss, nerve damage or prolonged pain or discomfort, painful or unattractive scarring. Hair loss can occur when incisions are made in the scalp, and although usually temporary, can be permanent.

## THIS PARAGRAPH PERTAINS TO SMOKERS

Smokers are recognized to have a significantly higher risk of post-operative wound healing problems as well as operative and post-operative bleeding. Patients should discontinue smoking one week prior to and two weeks after surgery. Although it helps to stop smoking for several weeks before and after surgery, this does not eliminate the increased risk resulting from long term smoking.

I consent to blood testing for HIV, if ordered by the physician. I understand that my results are confidential, but may be revealed to persons who have access to my record by law.

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## THIS PARAGRAPH PERTAINS TO FEMALE PATIENTS ONLY

Anesthetic agents can be harmful to the fetus of a pregnancy woman. Anesthesia should be avoided during pregnancy whenever possible. I hereby state that I am not pregnant and accept the responsibility of making this determination.

I certify that I have read filled out the patient registration and medical history form fully and correctly to the best of my knowledge, and that the information that I have supplied is complete and correct. I understand that withholding medical information could lead to complications or problems that may have been prevented if the information were know prior to my procedure.

I certify that my physician has discussed the procedure with me to my satisfaction, this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its consents. I have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of non treatment, the procedures used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.

I agree to follow the instructions given to me by the doctor to the best of my ability before, during and after the above mentioned surgical procedure and will notify him of any problems following my procedure.

## ARBITRATION AGREEMENT

**In consideration of the agreement of the undersigned physician and his professional association to undertake the treatment of the undersigned patient, and in further consideration of such professional services to be rendered and in acknowledgment of the dangers which may be inherent in or result from such treatment, it is agreed that any legal claim or civil action in connection with this treatment by or against the physician, his professional association, his employees or any physician signing this document or agreeing in writing to be bound by it, shall be settled by arbitration in accordance with the then current rules of the American Arbitration Association and the laws of the State of Florida and judgment upon the award or finding rendered by the arbitrators may be entered in any court having jurisdiction thereof. Arbitration will be a panel of three (3) arbitrators, two of whom will be attorneys, and the third arbitrator will be a physician who practices in the same medical community. The arbitration will be final and binding. Discovery will be strictly limited.**

**The undersigned patient, spouse, and/or legal guardian or parents, has, before signing this Arbitration Agreement, read and understands the same. It is understood that the proposed treatment rendered by the Doctor and his Professional Association is elective and, therefore, this agreement is not being executed under duress. Further, that all of the patients questions relating hereto have been answered to the patient's satisfaction.**

**I understand that my surgical deposit, if applicable, is not refundable, but is transferable to a different date, within 60 days of the original procedure date. I understand that the surgical fee is paid for the procedure itself, and that additional costs may be incurred by me if additional surgery is requested or in the event that complications or other events necessitate consultation with other physicians, hospitalization, or other services. I understand that such additional expenses will be borne by the patient alone. I understand that photographs may be taken to document my operation and post operative course. I consent to the publication of said photographs in the medical or scientific medium, in a manner which will not allow identification by facial features. I understand this facility is a "Doctor's Office", regulated pursuant to the rules of the Board of Medicine as set forth in rule chapter 64B8, F.A.C.**

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## SIGNATURES

**Do not sign this form unless you have read it and feel that you understand it. Ask any questions you might have before signing. E-signatures are legally binding.**

Patient Signature: _____ Date: _____

Physician / Witness Signature: _____ Date: _____