

COSMETIC SURGERY & DERMATOLOGY OF ISSAQUAH, INC.

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INFORMED CONSENT FOR SURGERY

I, _____ whose signature appears at the bottom of this form do hereby give my informed consent to Dr. _____ to perform the following operative procedure(s) :

- 1.
- 2.
- 3.

I have been informed, to my satisfaction, of the above mentioned procedure(s), why it is necessary, the risks to my health if the condition remains untreated and what the procedure will entail.

I understand that this will be a surgical procedure and that it will be performed under local anesthesia, most likely Xylocaine 1% with or without epinephrine, and that I have previously had no allergy to these agents. I realize that this procedure will be an operation done with a scalpel which is performed to remove diseased tissue. In doing so, some normal tissue will be removed and a scar will be formed. I give permission to my doctor to do this procedure in the manner which he considers to be best for me. He has my permission to make the best possible cosmetic closure; however, I understand that I am consenting to the treatment of a disease and the final scar result is secondary to the curing of the disease.

I have been made aware that there are certain risks inherent to the performing of any surgical procedure such as loss of blood, infection, reactions to anesthesia. and the formation of thick or otherwise objectionable scars. Additionally, I acknowledge that the doctor has made no promises to me, oral or written, in connection with the operation, I recognize that every surgical procedure involves uncertainty and that no result can ever be guaranteed.

I give permission to have any tissue removed during the procedure be sent for histologic examination by a pathologist.

I release the doctor from responsibility for any condition which takes place as a natural complication of the procedure. I also realize that it is my responsibility to keep post-operative appointments and perform postoperative care as instructed. If I feel that any problems exist such as bleeding or infection or if I have any doubts, I am to contact the doctor as soon as possible.

Signature of patient or patient's legal guardian signifying informed consent

Date

Witness

Date