HOUSTON DERMATOLOGY SPECIALISTS
Medical | Cosmetic | Mohs Surgery

Intake and History Form

Last Name: _____ First Name: _____ Date: _____

Street Address: _____ City/State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Phone Number (day): _____ Phone Number (night): _____

Email Address: _____ Social Security #: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Preferred Language: _____

Race: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian

☐ Native Hawaiian or Other Pacific Islander ☐ Other _____

Ethnic Group: ☐ Unspecified ☐ Declined to Specify ☐ Prohibited by State Law

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown.

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Insurance Information

Primary Insurance Holder Name: _____ Date of Birth: _____

Address: _____

Insurance Name: _____ Insurance Phone Number: _____

Member ID: _____ Group #: _____

Relation to Patient: _____

Secondary or Supplemental Insurance: _____

Insurance Name: _____ Insurance Phone Number: _____

Member ID: _____ Group #: _____

Pharmacy Name: _____ Phone Number: _____

Address: _____

"Failure to provide pharmacy information may result in a delay of prescriptions."

Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Urinary Incontinence Daily (QM 48)
- ☐ Other
- ☐ _____
- ☐ _____

Surgical History

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon (Colectomy): Colostomy
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): TURP
- ☐ Prostate (Prostatectomy): APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ **NONE**
- ☐ Other
- ☐ _____
- ☐ _____

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell Skin Cancer
- ☐ Blistering
- ☐ Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Squamous Cell Skin Cancer
- ☐ **NONE**
- ☐ Other
- ☐ _____
- ☐ _____

Do you use sunscreen?

☐ Yes ☐ No

If yes, what SPF? _____

Do you tan in a tanning salon?

☐ Yes ☐ No

Do you have a family history of **Melanoma**? (QM 137)

☐ Yes ☐ No

If yes, which relative?

☐ Mother	☐ Uncle	☐ Grandson
☐ Father	☐ Aunt	☐ Granddaughter
☐ Sister	☐ Nephew	☐ Other
☐ Brother	☐ Niece	☐ _____
☐ Daughter	☐ Grandmother	☐ _____
☐ Son	☐ Grandfather	

Medications (List all current medications)

_____

_____

Allergies to Medications (List all allergies and reactions, if known)

_____

_____

Smoking Status (please choose one) (QM 226)

☐ Current, Every Day Smoker
☐ Current, Some Day Smoker
☐ Former Smoker
☐ Never Smoker
☐ Unknown if Ever Smoked

Start Smoking (mm/dd/yyyy): _____
Quit Smoking (mm/dd/yyyy): _____
Total Years Smoking: _____
Number of Packs Per Day: _____

Alcohol Intake (please choose one)

☐ None
☐ 1 or less per day
☐ 1-2 per day
☐ 3 or more per day
☐ Other: _____

How often do you exercise?

☐ Once a day
☐ Several times a day
☐ A few times a week
☐ A few times a month
☐ Other: _____

What is your caffeine use?

☐ Unspecified
☐ Several times a day
☐ Once a day
☐ A few times a week
☐ A few times a month
☐ Never
☐ Other: _____

Advance Care (QM47)

Do you have a health care proxy in the event you are unable to make your own medical decisions?

☐ Yes ☐ No

If yes, name of proxy: _____

Phone number of proxy: _____

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Skin Health & Aesthetic Interests

(Skip this section if you're not interested at this time)

1. **Which area(s) of appearance would you like to improve?**

Choose based on your main goals:

☐ **Skin Maintenance**

→ Maintaining healthy skin, enhancing glow, and supporting prevention with regular upkeep treatments.

☐ **Texture & Skin Quality**

→ Improving acne scars, large pores, and rough or uneven skin texture for a smoother, more refined look.

☐ **Skin Pigmentation & Skin Tone**

→ Targeting concerns like sunspots, redness, and or uneven skin tone to promote a clearer, more balanced complexion.

☐ **Smoothing**

→ Best for softening expression lines such as forehead lines, frown lines, and crow's feet. Helps create a smoother, more refreshed appearance.

☐ **Volume Restoration**

→ Ideal if you're experiencing volume loss or want enhanced contours—such as fuller lips, lifted cheeks, or more defined facial structure.

2. Cosmetic Consultation

- Are you Interested in a complimentary consultation?
  ☐ Yes ☐ No

Contact Info:

Circle preference

- Preferred method (text, call, email)
- Best time (morning, afternoon, evening)

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HIPAA Release

What is your preferred contact number?

☐ Home _____ ☐ Work _____ ☐ Cell _____

I hereby grant Houston Dermatology Specialists permission to notify me by telephone of the following:

☐ Message to call the office for test results (the actual results will not be left).
☐ If the results are benign, a message will be left stating no further treatment will be needed and to keep any advised follow-up as recommended by your physician.

I hereby authorize Houston Dermatology Specialists to disclose my personal medical information pertaining to my diagnosis and/or treatment, biopsy results, medical history, or any other information to myself and those listed below.

Name: _____ Phone: (___)_____ Relationship: _____

Name: _____ Phone: (___)_____ Relationship: _____

Name: _____ Phone: (___)_____ Relationship: _____

Assisted Living/Long-Term Care Facility Patient: Please list any facility personnel that we are allowed to speak with on your behalf regarding your medical information.

Name: _____ Phone: (___)_____ Relationship: _____

Name: _____ Phone: (___)_____ Relationship: _____

Name: _____ Phone: (___)_____ Relationship: _____

Do you have a Power of Attorney: ☐ Yes ☐ No (If yes, please list below)

Name: _____ Phone: (___)_____

(If yes, please include a copy of the Power of Attorney paperwork to Houston Dermatology Specialists)

All Patients: The duration of this authorization is indefinite unless otherwise revoked in writing. I understand and authorize the release of this information to other healthcare providers associated with my care to facilitate other healthcare treatment. I further understand that records for medical information from persons not listed above will require specific authorization prior to disclosure of my medical information.

Signature: _____ **Date:** _____

Printed Name: _____

(Parent/guardian authorizes and signs on behalf of _____ (**name of minor**)

HIPAA NOTICE OF PRIVACY PRACTICES AND NOTICE CONCERNING COMPLAINTS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Effective August 6, 2022
PLEASE REVIEW IT CAREFULLY

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

We may use and disclose your medical records for each of the following purposes:

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. This includes downloading an electronic record of your current and past prescription medications. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health Care Operations includes the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

We May also use and disclose your medical records for:

- Public health purposes;
- To protect victims of abuse, neglect, or domestic violence;
- Health oversight activities such as investigations, audits, and inspections;
- Law enforcement purposes;
- Lawsuits and similar proceedings;
- When otherwise required by law;
- When requested by law enforcement as required by law or court order;
- To coroners, medical examiners, and funeral directors;
- Organ and tissue donation;
- Research under strict federal guidelines;
- Reduce or prevent a serious threat to public health and safety;
- Workman's compensation or other similar programs if you are injured at work;
- Accreditation purposes; and
- Specialized government functions such as intelligence and national security.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request that we restrict the disclosure of certain health information to a health plan if the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid out of pocked in full.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
  The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.
- The right to receive a privacy breach notice through written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.
- The right to request an electronic copy of your protected health information.

To request a copy of your protected health information please contact our Magnolia office at (281)-677-3091or our Houston office at (713) 487-8233 via phone call. Please allow 24 hours for your protected health information to be obtained. After 24 hours you may pick up the requested copies of your records from the office location of your choice. Email is not a HIPPA approved form of communication, however, it is available with the patients' written consent.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post revisions in our premises.

Please contact us for more information:

Jacob Shaw, Privacy Officer
Houston Dermatology Specialists
13114 FM 1960 Rd W
Suite 119
Houston, TX 77065
(713) 487-8233

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
(202) 619-0257
Toll Free: 1-877-696-6775

NOTICE CONCERNING COMPLAINTS

Effective January 31, 2026

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, surgical assistants, medical radiologic technologists, non-certified radiologic technicians, respiratory care practitioners, medical physicists, and perfusionists may be reported for investigation at the following address:

Texas Medical Board
Attention: Investigations
1801 Congress Avenue, Suite 9.200
P.O. Box 2018
Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353

For more information, please visit the following website: www.tmb.state.tx.us

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RECEIPT OF NOTICE
PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I hereby acknowledge that I received the Notice of Privacy Practices from Houston Dermatology Specialists which sets forth the ways in which my person health information may be used or disclosed by Houston Dermatology Specialists and outlines my rights with respect to such information.

Signature: _____

Date: _____

Printed Name: _____

(Parent/guardian authorizes and signs on behalf of _____ **(name of minor)**

HOUSTON DERMATOLOGY SPECIALISTS
Medical | Cosmetic | Mohs Surgery

Christopher Downing, M.D., FAAD
Board-Certified Mohs Surgeon and Dermatologist

Houston Dermatology Specialists (HDS) Financial Policy and Procedures

Patient Responsibilities

1. To know and understand the terms, guidelines, and limitations of their insurance plan including their co-payment, co-insurance, and deductible.
2. To provide proof of insurance (Driver's License and Insurance Card) *before* seeing a physician. All patients are required to present this information at every visit.
3. To pay any and all verified deductibles, co-insurance, and co-pays *at the time of service.*
4. If your insurance requires a referral, it is your responsibility to provide the referral prior to your visit.

Payment Collection and Non-Payment Policies

HDS accepts cash, check, debit cards, and credit cards.

1. *Self-Pay Patients*
   You are responsible for the entire amount of the bill at the time of service. Rates for self-pay patients are discounted at the Medicare rates. If you do not pay the discounted rate at the time of service, you are subject to pay at the full rate. The patient agrees to pay the balance in full at the time of service.
2. *Patients with Insurance*
   You are responsible for all deductibles, co-insurance, and co-pays at the time of service. We will work to provide you with an estimate of your final amount owed at the time of your appointment. If additional money is owed, we will attempt to notify you via phone and charge your credit card on file. The patient agrees to pay the balance in full at the time of service.
   - Insurance Claims are, at times, denied for non-eligibility, non-covered service, preauthorization or precertification not obtained, and/or for many other reasons. I understand that I am fully responsible for all balances not covered by my insurance company for services rendered to me or my dependents at Houston Dermatology Specialists.
3. *All Patients*
   You will be assessed a $25 return check fee if you pay with a check and that check is returned by the bank for any reason including, but not limited to, insufficient funds. If a check is returned, you will be required to pay for the full balance and all future visits with cash, debit card, or credit card.

Credit Card on File Notice

Christopher P. Downing, M.D. Dermatology, P.A. d/b/a Houston Dermatology Specialists utilizes a convenient payment policy using a credit or debit card held on file. Insurance companies increase co-payments, co-insurance, and deductibles each year. This transfers additional cost to the patient. To make managing payments easier for you and our staff, a credit card or debit card will be held at the time of check-in. The benefit is that you will not have to worry about statements and mailing in payments. Having a credit card on file will make check-in and check-out easier, faster, and more efficient for our patients. Your card information will be held securely and for your convenience used if there is any remaining balance after your visit to Houston Dermatology Specialists.

Our office personnel will not have access to your card information. Our electronic health record stores credit card information via PayJunction, a secure credit card processor. Only the last four digits of your card will show in our system. Our staff will make every attempt to contact you via phone calls, texts, and email prior to running your card for any balance or refund.

Credit Card on File May be Used For:

1. Co-payments: You may elect to use your credit card on file or another form of payment accepted by our office, if preferred.
2. Deductibles: Your card on file will be used to settle any deductible amount(s) due. Houston Dermatology Specialists strives to provide you with an accurate estimate based off of your insurance coverage and will charge this fee at time of check-out. If Houston Dermatology Specialists collects this amount, you will be notified that the credit card on

file will be used to settle the remaining balance. Co-insurance: Your card on file will be used to pay your percentage not covered by insurance. For example, if your insurance covers 90% of your total amount due, the remaining 10% balance is to be paid at the time of check-out.

3. Outstanding balances: If your account has a previous outstanding balance for any reason, your credit card on file will be used to settle that outstanding balance. We will provide courtesy calls, text, and email to let you know there is an outstanding balance on your account and that we will process it with your credit card on file.

By signing this form, you hereby authorize Houston Dermatology Specialists to bill your card on file and process any outstanding amounts as described above. Receipt of any transaction will either be forwarded to the home address in our files or emailed to you.

No Show or Cancellation Fee

We strive at Houston Dermatology Specialists to maintain a well-balanced schedule and provide each patient with the time needed for their medical concern. As such, there is a **$50 charge** applied to your credit card on file for cancelling your appointment with **less than 24 hours' notice** or for not showing to your appointment. For Monday appointments, your appointment must be cancelled by noon on Friday. For surgery patients, this fee is **$100**.

Surgery Deposit Fee

All surgical appointments at Houston Dermatology Specialists require a **$500 deposit** to hold your appointment. This fee will apply to your final amount owed. If nothing is owed at the time of your visit, this amount will be refunded to you on the day of your surgery.

Cosmetic Fees and Products

All product sales and cosmetic charges are final in the office (no exchanges or returns allowed).

Pathology and Lab Fee

Surgical procedures and biopsies will result in the physicians at Houston Dermatology Specialists sending your tissue sample to an outside lab for a diagnosis by a pathologist, who is not directly affiliated with the office. This is necessary for your medical care and for an accurate diagnosis and treatment plan. There will be a charge for the physician performing the biopsy or surgery at Houston Dermatology Specialists and another for the pathologist at the outside facility. Houston Dermatology Specialists' billing team is not affiliated with this outside lab and it is the patient's responsibility to determine the level of coverage and/or payment for these services. The physicians at Houston Dermatology Specialists may also order lab work as part of your ongoing medical treatment. Lab work will be performed at an outside lab such as Quest or LabCorp. It is the patient's responsibility to determine their level of coverage and/or payment for these services.

Other Procedures

There may be outside fees for specialized procedures associated with your visit that are not covered by your co-pay or co-insurance. This includes biopsy of skin lesions, treatment of lesions with cryotherapy or Canthacur, intralesional or intramuscular injection of medication, electrodessication and curettage, excision, and Mohs surgery. Cosmetic treatment of skin lesions is not covered by insurance under any circumstances. Payment of all of these services is due at the time of procedure.

By signing below, I acknowledge that I have read and fully understand and agree to the Houston Dermatology Specialists Financial Policy and, specifically authorize the credit card or debit card charges incurred in connection therewith, utilizing the credit card or debit card information that I authorize to be on file with Houston Dermatology Specialists.

Signature: _____ **Date:** _____

Printed Name: _____

(Parent/guardian authorizes and signs on behalf of _____ (**name of minor**)

HOUSTON DERMATOLOGY SPECIALISTS
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ASSIGNMENT OF MEDICAL BENEFITS, ERISA CLAIMS AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

The undersigned assigns and conveys directly to Houston Dermatology Specialists ("HDS") all medical benefits and/or insurance reimbursements to me for services, treatments, therapies and/or medications rendered to or provided by HDS and further authorize and designate HDS as my authorized representative for purposes of all medical benefits and insurance reimbursements thereunder.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to HDS any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort fees, or insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from HDS (including any right to pursue those legal or administrative claims or chose an action). I acknowledge and agree that this is an assignment of Employee Retirement Income Security Act, as amended (ERISA") breach of fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to HDS all my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by HDS including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). HDS is hereby given the right by me to (1) obtain information regarding the claim to the extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. HDS, as my assignee and my designated authorized representative, may also bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

I agree and acknowledge that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize HDS to release all medical information necessary to the applicable third parties to process my claims. Additionally, I hereby authorize my plan administrator fiduciary, agent, insurer, and/or attorney or attorney-in-fact to release to HDS all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

This Assignment is valid until further revoked in writing by the undersigned.

I HAVE READ AND FULLY ACKNOWLEDGE AND UNDERSTAND THE FOREGOING.

_____ _____

Patient Signature Date

HOUSTON DERMATOLOGY SPECIALISTS
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General Care and Treatment Consent

Patient Name: _____ **Date of Birth:** _____

To the patient: In consultation with your physician at Houston Dermatology Specialists, you have the right to be fully informed of your diagnosis/condition and any recommended medical care. This may include the recommendation for a diagnostic procedure and/or surgery. We will strive to ensure you have all the necessary information, including risks and/or benefits of the indicated procedures, so that you may make an informed decision that is right for you.

In order to ensure that you understand all aspects of your visit, you are encouraged to ask questions or clarify any procedure prior to them being performed. This consent form obtains your permission to perform the evaluation necessary to identify the appropriate medical care, surgical care, and/or diagnostic procedure. This consent also provides us with your permission to perform reasonable and necessary medical examinations, procedures, testing, and treatment.

I voluntarily request Joel Byrne, MD, Christopher P. Downing, MD, and/or Rachel Gordon MD, and their associates, assistants, nurses, and Houston Dermatology Specialists as deemed necessary, to perform reasonable and necessary medical examinations, testing, and treatment for the condition which has brought me to seek care at this practice. Such procedures include but are not limited to:

Full skin examination, skin biopsy, cryotherapy, steroid injection, local injection of chemotherapy medication (such as 5-Fluorouracil, Bleomycin), application of Canthacur, application of squaric acid, cauterization of skin lesions, and Unna boot application with topical medications. **Should a biopsy be performed, or any other procedure in which a section or your skin is removed, the specimen will be sent to a pathology lab for an accurate diagnosis** unless otherwise recommended by your clinician.

With any procedure, there are risks involved which include, but are not limited to:

1. Bleeding: Some procedures may cause minor bleeding. Rarely someone will have significant bleeding after the procedure that would require follow up to have us treat it.
2. Scarring: Scarring is possible with any skin procedure. We will do everything we can do to provide the best cosmetic outcome possible, but the final outcome is not guaranteed.
3. Infection: A small number of people will get a wound infection requiring treatment.
4. Nerve Damage: Although extremely rare, it is not impossible to have nerve damage with select skin procedures.

By signing below, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature: _____ **Date:** _____

Printed Name: _____

(Parent/guardian authorizes and signs on behalf of _____ (**name of minor**)