# PATIENT CONSENT FORM FOR TREATMENT OF WARTS

I hereby authorize Dr. _____ to treat my wart(s) using a laser device. I understand that multiple treatments may be required and it is possible the result will be minimal or may not help at all. I further consent to the administration of various types of local anesthetics, numbing medications.

The Procedure may result in the following adverse experiences or risk:

- DISCOMFORT – Some discomfort may be experienced during treatment.
- REDNESS/SWELLING/BRUISING – Short term redness (erythema) or swelling (edema) of the treated area is common may occur. There also may be some bruising.
- SKIN COLOR CHANGES – During the healing process, there is a possibility that the treated area may become either lig (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, on a rare occasion, it may be permanent.
- WOUNDS – Treatment can result in burning, blistering, or bleeding of the treated areas. If any of these occur, please call office.
- INFECTION – Infection is a possibility whenever the skin surface is disrupted, though proper wound care should prevent this. If signs of infection develop, such as pain, heat or surrounding redness, please call our office (401) 861-8830.
- SCARRING – Scarring is a rare occurrence, but it is a possibility of the skin surface is disrupted. To minimize the chance scarring, it is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff.
- EYE EXPOSURE – Protective eyewear (shields) will be provided to you during the treatment. Failure to wear eye shield during the entire treatment may cause severe and permanent eye damage.

I acknowledge the following points have been discussed with me:

- Potential benefits of the treatment of warts, including the possibility that the procedure may not work for me.
- Alternative treatment such as topical or oral medications or even surgery.
- Reasonably anticipated health consequences if the procedure is not performed.
- Possible complications/risk involved with the proposed procedure and subsequent healing period.

For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Furthermore, I agree to keep Dr. _____and staff informed should I become pregnant du the course of treatment.

## ACKNOWLEDGMENT

**BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS INFORMED CONSENT FORM FOR TREATMENT OF WARTS, AND THAT I HAVE HAD AL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.**

| _____ | _____ | _____ |
|---|---|---|
| **Signature-Patient or Guardian** | **Print Name/Relationship** | **Date** |
| _____ | _____ | _____ |
| **Signature-Witness** | **Print Name** | **Date** |

# MORTON'S NEUROMA

I hereby authorize Dr._____ or associates to perform a series of alcohol sclerosing injections. A commonly used anesthetic and 98% dehydrated alcohol is injected into the involved interspace(s) at approximately 1 to 2 weeks intervals.

The side effects are minimal (some patients reported a burning sensation at the injection site 24 hours after the first injection) and there is no down time. Potential risks e.g. bleeding, bruising, infection, menstrual irregularity, post injection pain, soft tissue atrophy, and de-pigmentation of the skin.

I also understand that multiple injections may be required before my condition improves and that my condition may not improve even after the injection(s).

I have read the above and understand it. I have been given the opportunity to ask questions and they have been answered to my satisfaction. I accept the risks and complications of the procedure as stated above, and consent to the terms of this agreement.

| _____ | _____ | _____ |
|---|---|---|
| Patient Name | Patient Signature | Date |

_____
Witness

3/2015

# CONSENT TO OPERATION

**PATIENT**_____ **AGE**_____

**DATE**_____ **TIME**_____ **PLACE**_____

1. I authorize the performance upon_____ of the following operation
   (Myself or name of Patient)

   _____
   (State nature and extent of operation)

   _____

   to be performed under the direction of Dr._____.

2. I consent to the performance of operations and procedures in addition to or different from those now contemplated, whether or not arising from presently unforeseen condition, which the above named doctor or his associates may consider necessary or advisable in the course of the operation.
3. I consent to the administration of such anesthetics as may be considered necessary to advisable. Potential risks e.g. bleeding, bruising, infection, post injection pain, soft tissue atrophy, and de-pigmentation of skin.
4. I consent to the photographing or television of the operation or procedures to be performed including appropriate portions of my body for medical, scientific or educational purposes, provided my identity is not revealed by the pictures or by descriptive texts accompanying them.
5. I consent to the disposal by Dr._____ of any tissues or parts, which may be removed.
6. The nature and purpose of the operation, possible alternative methods, treatment, and/or risk(s) involved and the possibilities of complications have been fully explained to me.

No guarantee or assurance has been given by me or anyone as to the result that may be obtained.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO OPERATION, THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE, THAT ALL BLANKS OR STATEMENTS IN APPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED.

I ALSO CERTIFY THAT I AM PERSONALLY RESPONSIBLE FOR ALL SURGICAL FEES AND THAT I HAVE RECEIVED A PRE-OPERATIVE INSTRUCTION SHEET AND MEDICATION, WHICH WAS EXPLAINED TO ME IN ADVANCE AND WHICH I THOROUGHLY UNDERSTAND.

Signature of Patient: _____

Signature of Patient's husband or wife: _____

**When a patient is a minor or incompetent to give consent:**

Signature of person authorized to consent for patient: _____

Relationship to Patient: _____

The foregoing consent was read, discussed and signed in my presence and in my opinion the person(s) so signing did so freely with full knowledge and understanding.

Signature of witness: _____

# STEROID INJECTION/PERIPHERAL ANESTHETIC BLOCKS

Informed Consent

Intralesional and subcutaneous steroid injections are often performed to decrease pain, swelling and inflammation. The procedure consists of a steroid suspension and local anesthetic injected into the skin in a sterile fashion.

I understand there is a possibility of rare side effects. Potential risks e.g. bleeding, bruising, infection, menstrual irregularity, post injection pain, soft tissue atrophy, and de-pigmentation of the skin.

I have read the above and understand it. I have been given the opportunity to ask questions and they have been answered to my satisfaction. I accept the risks and complications of the procedure as stated above, and consent to the terms of this agreement.

| Patient Name | Patient Signature | Date |
|---|---|---|

Witness

3/2015

CONSENT TO INJECT

Patient Name:_____ Age:_____ DOB: _____

Location of Injection:_____ Date:_____

I authorize the performance upon myself for the treatment of the following:

- ☐ Plantar Fasciitis
- ☐ Neuroma
- ☐ Sinus Tarsitis
- ☐ Tendonitis
- ☐ Arthritis
- ☐ Tarsal Tunnel Syndrome
- ☐ Other_____

The following issues have been discussed:

- The nature of the procedure and the reason for the injection has been explained and advice about aftercare provided.
- Any allergies including dressings and antibiotics.
- The potential risks e.g. bleeding, bruising, infection, menstrual irregularity, post injection pain, soft tissue atrophy, and de-pigmentation of the skin.

I consent to the procedure as described to me by my doctor. I have read and understood the information detailed above and understand fully the reasons for the procedure.

Signature of Patient or Parent/ Guardian:_____ Date:_____

Parent/ Guardian Name: _____

Witness: _____