CONSENT FOR PROCEDURES

ATOMIC DERMATOLOGY
Vicki Haines DCNP

The undersigned authorizes Atomic Dermatology, LLC (i) to perform dermatology (skin care) services on the patient named below, which may include cancer evaluation and the removal of any suspected cancer lesion, as more fully explained on the second page to this Consent for Procedures; and (ii) to bill the appropriate party (including Medicare and/or other insurance) for such services.

Authorization and Consent of Patient

(if patient is unable to provide consent, obtain authorized signature in section below)

PATIENT SIGNATURE: _____

WITNESS SIGNATURE: _____

Authorization and Consent of Legal Guardian or Holder of Power of Attorney

The individual signing on behalf of the patient hereby represents and certifies that he or she holds a valid power of attorney for the patient or is the patient's legal guardian and has the power and authority to execute this consent and authorization for treatment on behalf of the patient.

SIGNATURE: _____

PRINT NAME OF SIGNATORY: _____

WITNESS SIGNATURE: _____

CONSENT FOR PROCEDURES (Continued)

1. My authorization signature on the preceding page hereby authorizes Atomic Dermatology, LLC personnel to perform upon the named patient, medically necessary evaluation of suspicious skin abnormalities, possible biopsy and removal of precancerous and cancerous skin lesions. In addition, I understand and agree with all of the items listed below.

2. If any unforeseen conditions arise during the course of these procedures, I do hereby authorize Atomic Dermatology, LLC personnel to take whatever steps, and to perform whatever procedures they deem advisable which may be in addition to or different from those now planned.

3. I understand that there are always certain risks and consequences that are associated with the aforesaid procedures. These, among others, are scarring, pigmentary changes to the skin, reoccurrence of skin cancer or other lesion/problems, and possible damage to blood-vessels, or parts next to them, such as nerves, infection, or allergic reactions or other complications.

4. I acknowledge that no guarantee or assurance has been made to me as to any of the results or risks, and I assume such risk, and that the practice of medicine is not an exact science, and I understand these facts. I will ask if I want to have further explanation, discussion or description of the risks involved in these procedures.

5. I consent to the disposition by Atomic Dermatology, LLC of any tissue parts, which may be removed from named patient. I understand that this tissue will be sent for pathologic evaluation to a board-certified dermatopathologist and that named patient will be financially responsible for all the charges related to this evaluation regardless of the reimbursement from insurance carrier. I also understand that I will not hold Atomic Dermatology, LLC professionally or personally responsible for the pathologic interpretation of said tissue and that this tissue may be sent for additional tests or evaluation at my or my insurance companies' expense.

6**. FOR PATIENT UNDERGOING SKIN CANCER TREATMENT**: I understand that I have skin cancer and that it is my responsibility to seek follow-up care by Atomic Dermatology, LLC personnel or other dermatology professionals in one (1) month then every three (3) month in the first year, every four (4) months the second year, every six (6) months the third, fourth and fifth years, and then yearly for the rest of my life. Failure to see follow-up care is my responsibility and I do not hold Atomic Dermatology, LLC personnel professionally or personally responsible for skin cancer follow up.