

Charlottesville Dermatology, PLC

Anna Magee, M.D., Deborah Elder, M.D., Chelsi Miller, NP
600 Peter Jefferson Parkway, Suite 230
Charlottesville, VA 22911
Tel: 434-984-2400 Fax: 434-984-1147

Informed Consent

My signature on this form authorizes the Doctors and or Clinical Staff of Charlottesville Dermatology PLC to perform procedures on me that they feel are necessary for my well being, including, but not limited to injections, freezing with liquid nitrogen (cryosurgery), electro desiccation, biopsy, excisions, suture removals, and topical anesthetics. Before any procedure is done, I will be informed, to my satisfaction why the procedure is necessary. I will be told what the procedure involves and what risk there is to my health, if any, if the condition were to remain undiagnosed or untreated.

Initials: _____

I understand the risk inherent to the performance of any surgical procedure such as loss of blood, infection, reaction to anesthesia and the formation of thick or otherwise objectionable scars, and I realize that such, or any, natural complications that result from the surgical procedure.

Initials: _____

I give my permission to have any tissues(s) removed during the procedure or lab tests to be sent for histologic examination by a pathologist. I understand that I will likely receive a separate bill for the interpretation of such specimens.

Initials: _____

I will alert Charlottesville Dermatology PLC immediately if any complications or problems should occur.

Initials: _____

Patient Name (print): _____ Chart #: _____

Patient Signature: _____ Date: _____
(or Parent/Legal Guardian)

Witness: _____ Date: _____
(Charlottesville Dermatology PLC Representative)