Andrea Trowers M.D., P.A

AUTHORIZATION FOR MEDICAL TREATMENT, ADMINISTRATION OF ANESTHESIA AND THE PERFORMANCE OF OPERATIONS AND/OR PROCEDURES

1. I do hereby authorize the use of and the administration of such drugs, anesthetics, and other treatments and the performance of a skin biopsy that has been deemed advisable, desirable or necessary for diagnostic, therapeutic, or investigational purposes by Dr.Trowers for or upon me or my minor.

2. I further consent to the examination for diagnostic, investigational purposes, and disposal by authorities of the above named medical facility of any tissue or parts which may be removed.

3. I understand that the skin biopsy involves removal of a piece of skin and that such removal may result in permanent scar or in discoloration of the skin at the site of the biopsy.

4. I understand that this procedure may have some unwanted results, which include, but are not limited to permanent scarring discoloration of the skin, infection, bleeding, nerve damage – resulting in temporary or permanent numbness or temporary or permanent loss of function of certain muscles (paralysis.)

5. All specimens are sent for dermatopathologic analysis to our laboratory. Charges for dermatopathology will be billed to your insurance but in certain cases, individuals may be responsible for a portion or all of the charges.

6. I recognize the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.

7. I understand that the medications used to treat acne (creams, gels and pills) are category C and/or X. The patient or their significant other should not be trying to get pregnant or pregnant while on these medications because it would be dangerous to the developing baby. (Any questions will be discussed during the appointment.)

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT AND THE EXPLANATIONS CONCERNING THE ABOVE ITEMS WERE MADE TO ME.

I authorize the release of medical information to my primary care or referring physician, to consultants if needed as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payments of all medical or surgical benefits to which I am entitled to Dr. Andrea Trowers.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered, applicable co-payments and deductibles will be collected. We accept payment in the forms of cash, check or credit card. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party:

_____ _____ _____

Print Signature Date

Is the office staff authorized to leave a message at a specific phone number regarding the results of any biopsies that may be done today or at a future date? YES NO

If yes, at what phone number may a message be left? _____