Information and Consent for Laser and Radio Frequency Surgery (Lumps and Bumps)

Dr. Zimmerman has recommended:

- O **Biopsy**
- O **Excision/Destruction**
- O **Test Spot**
- O **Superficial/Mid-depth/Deep skin resurfacing**
- O **Suture closure**
- O **Other: ______________________________________**

On my: ____

PROCEDURE:

- The procedure starts with cleansing the skin. Anesthetic is the applied and/or injected around and into the surgical site. There is a rare risk of allergic reaction to the anesthetic or cleansing solutions
- Next, minimally invasive surgery is performed. Stitches are/are not required. A specimen will/will not be sent to a pathologist for evaluations.
- The risks to this procedure are small if you follow the post-procedure instructions. They include local infection, bleeding, prolonged redness, hyper or hypo-pigmentation and scarring.
- The treated area may heal either lighter or darker than the surrounding skin. This is usually temporary for superficial treatments but can be permanent with deeper treatments.
- There will be some post-operative discomfort. Temporary bleeding, bruising, and swelling are normal.

CONSENT:

PLEASE INITIAL YOUR UNDERSTANDING NEXT TO EACH PARAGRAPH

PHOTOGRAPHS

- I consent to photographs/videos for medical records, education, and advertising. If used for education or advertising, I will not be identifiable.
  Initial: _____________

POST-OPERATIVE TREAMENT

- I agree to follow a specific post-operative treatment plan, which has been reviewed with me by the staff (see separate sheet). I understand that smoking and blood thinning drugs (aspirin, Vit E, garlic, ginkgo, etc.) can interfere with healing. **Initial: _____________**

ALTERNATIVES

- Alternatives to this procedure such as: freezing, cutting, injections, chemical treatments, the use of different lasers or IPL, or doing nothing has been discussed. **Initial: ______________**

PATIENT CERTIFICATION:

- I fully understand that the goal of this procedure is improvement and not perfection
- I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees can be made as to the eventual results of this procedure. I have had the opportunity to discuss my condition and the proposed treatment with Dr. Zimmerman and his staff. All of my questions have been answered to my satisfaction. I believe I have adequate knowledge on which to base an informed consent to this procedure. This consent will be effective for the duration of laser sessions needed to treat the condition(s) named above.

___________________________________ ____________
Signature of Patient Date

___________________________________ ____________
Physician/Staff Signature Date