Southdale pediatric associates, ltd.

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CONSENT FOR WART TREATMENT

Date: _____

Patient Name: _____ Date of Birth: _____

The above patient has been diagnosed with a wart, multiple warts, molluscum contagiosum, and/or other skin lesions. I have read the information sheet and am aware of the following:

- There is no single treatment that can guarantee successful treatment of warts.
- Multiple office visits may be required for more stubborn warts.
- In office liquid nitrogen therapy is considered a surgical procedure and will be billed accordingly.
- The treated area(s) may develop new lesions.
- The treated area(s) may have recurrences of previously treated lesions.
- The treated area(s) may develop a scar.

MY SIGNATURE BELOW REPRESENTS MY WILLINGNESS TO PROCEED WITH THE PROCEDURE FULLY REALIZING THE ABOVE STATEMENTS.

Since each insurance company has its own policies regarding the coverage of wart treatment, I acknowledge that the responsibility for payment in full for the charges incurred for wart treatment is the responsibility of the patient or person responsible for the bill regardless of the coverage provided by the insurance company that insures the patient. Any balance after payment by the insurance company, such as co-payments, unmet deductible, or non-coverage, is the responsibility of the patient or guarantor.

Patient Signature: _____ Date of Service: _____

Or, if patient is under 18 years of age:

Parent/Guardian Signature: _____ Date of Service: _____