CAROLINE R. PRICE M.D., P.A.

10 Enterprise Boulevard, Suite 207
Greenville, South Carolina 29615
864-331-2505 telephone
864-331-2510 facsimile

STATEMENT OF INFORMED CONSENT

PATIENT NAME: _____

1. The nature of my illness, purpose of the operation and alternative treatments, risks and possible complications have been explained to me.
2. I understand that the complications include but are not limited to: allergic reaction, pain, bleeding, infection, slow healing, skin color change, numbness, scar (depressed, flat, hypertrophic or keloid), recurrence, possible need for additional testing (biopsy, surgery, blood work) and _____.
3. I acknowledge that no guarantee has been made as to the outcome of this surgery or procedure.
4. Please check yes or no if you have the following medical problems or conditions:

YES	NO	
_____	_____	**allergies to Lidocaine, Epinephrine, Betadine, or Polysporin**
_____	_____	**a pacemaker**
_____	_____	**a bleeding disorder**
_____	_____	**susceptibility to infection**
_____	_____	**a previous adverse reaction to Surgery**
_____	_____	**a previous adverse reaction to anesthetic**
_____	_____	**I take other prescription or herbal Medications**
_____	_____	**I take aspirin or other blood thinners**
_____	_____	**an artificial joint**
_____	_____	**heart valve abnormalities**
_____	_____	**I require antibiotics prior to dental work**
_____	_____	**currently pregnant or breastfeeding**

5. I consent to the admission of observers for the purpose of advancing medical education.
6. Acknowledging the above statements, I hereby give my informed consent to perform:

   Treatment of skin tags Shave removal Biopsy Full thickness excision

   Curettage with electrodessication of: _____
7. I understand that the above described procedure is to be performed by Dr. Caroline Price.
8. I have been advised that the anesthetic is necessary and consent to the administration of: 2% xylocaine with/without epinephrine or other:_____
9. I consent to the examination, testing or disposal of any tissue or parts that may be removed, including their use for research purposes. I understand that the pathologist will send me a separate bill.
10. I consent to photographs of my condition and/or procedure performed and the use of the images for the purpose of advancing medical education.
11. I understand that I have requested this procedure and I will be financially responsible for this service if it is not covered under my health benefit plan.

I have read, understand, and agree to the above Consent Form and know that I will be responsible for pathology lab services associated with this procedure.

Signature: _____ Date: ____/____/____ Relationship: _____

Witness: _____ Date: ____/____/____