Shining Way Esthetics

Skin Tag Removal Informed Consent

To the patient: You have a right to be informed about your condition and its treatment, so that you may decide whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give, or withhold, your consent for treatment.

I, _____, understand that I will be receive one of the following procedures: Check One: ___ Cosmetic Shave Removal ___ Cosmetic Skin Tag Removal.

My signature on this form authorizes Dr. Adherbal "Herb" De Souza Neto, DNP, WHNP-BC. MEP-C to perform the referenced procedure(s):

1. I have been informed, to my satisfaction, regarding the nature of the procedure and acknowledge that this procedure is entirely a cosmetic procedure. I acknowledge that I have been medically cleared by my private doctor concerning this procedure and have previously addressed any concerning lesions/moles on my skin. I acknowledge and understand that Shining Way Esthetics nor any staff member will not send any tissue to have any pathology analysis which lesions or moles which may be treated.

2. I have been informed, to my satisfaction, regarding the risks inherent to the performance of this procedure such as loss of blood, infection, reaction to anesthesia and the formation of thick or otherwise objectionable scars, thinning of the skin, discoloration, atrophy and recurrence of the lesion/mole. Should any type of skin infection occur, additional treatments or medical antibiotics may be necessary from my private doctor or Shining Way Esthetics.

3. I understand that medical care requires my cooperation, and I will follow all post care instructions. If indicated, I will make and keep appointments for follow-up care and call the office to note any changes or concerns in my condition.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

I understand there is no guarantee of results of any treatment. I understand regular charges applies to all subsequent treatments. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand there are

no refunds on any services rendered. I further agree in the event of nonpayment, to bear the cost of collection, and/or court cost and reasonable legal fees, should this be required.

I release Shining Way Esthetics, medical staff and technicians from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns. Note: All prices are subject to change without prior notice. I consent to photographs being taken to evaluate treatment effectiveness, for medical education, training, professional publications, or sales purposes. No photographs revealing my identity will be used without my written consent.

Patient Signature: _____ Date: _____

Printed Name: _____

Practitioner Signature: _____ Date: _____

Printed Name: _____