Roni W. Ford, M.D.

Anne E. Rothman, M.D.

Center for Cosmetic and Clinical Dermatology

6 Montgomery Village Avenue, Suite 322
Gaithersburg, MD 20879

BIOPSY CONSENT

During your visit, the dermatologist may need to perform a skin biopsy to evaluate your skin condition. Please review and sign below. **You will be given ample time to discuss the procedure if the doctor determines that a skin biopsy is necessary.**

PATIENT NAME: _____ DATE: _____

PURPOSE:

A biopsy is a surgical procedure used to obtain a sample of tissue for microscopic examination to aid the physician in diagnosis. The entire lesion may not be removed in this procedure. Further medical or surgical treatment may be needed when the diagnosis is made.

PROPOSED TREATMENT:

I understand that a biopsy requires obtaining a sample of tissue and is a surgical procedure. As in any surgical procedure, there are certain inherent risks including bleeding, post-operative pain, infection, reactions to sutures, anesthetics or topical antibiotics, and scarring. Although all reasonable efforts will be made to minimize the possibility of these potential complications, no guarantees can be made since many factors beyond the control of the physician (such as the degree of sun damage or patient compliance with post-operative instructions)affect the ultimate healing.

A pathologist will examine the tissue obtained in this biopsy procedure. I understand that I may receive a separate bill from the pathologist or laboratory for this microscopic examination.

OTHER ACKNOWLEDGMENT DISCLOSURES:

I am able to read and understand English.

CONSENT:

PATIENT (OR LEGAL GUARDIAN) SIGNATURE: _____ DATE: _____

PHYSICIAN SIGNATURE: _____ DATE: _____