

## Consent Form for Warts Treatment

Today's Date: \_\_\_/\_\_\_/\_\_\_

Patient Name: \_\_\_\_\_ Patient's Date of Birth: \_\_\_/\_\_\_/\_\_\_

My name and signature on this consent form indicates that the physician has explained to me that the diagnosis of warts has been. Specifically, the type of wart is called:

- |   |   |
|---|---|
| <input type="checkbox"/> Verruca Vulgaris     | <input type="checkbox"/> Molluscum Contagiosum      |
| <input type="checkbox"/> Flat, juvenile warts | <input type="checkbox"/> Genital warts of the _____ |
| <input type="checkbox"/> Verruca Plantaris    | <input type="checkbox"/> Condyloma                  |
| <input type="checkbox"/> Condyloma Acuminatum | <input type="checkbox"/> Viral warts                |
| <input type="checkbox"/> Verruca Plana        |   |

**The physician has explained to my satisfaction the following: *(Please initial each line)***

- \_\_\_ There is no single treatment that can guarantee successful treatment of the warts.
- \_\_\_ Wart treatment may require one or more methods or combinations of several treatment options.
- \_\_\_ Multiple treatments may be required.
- \_\_\_ The treatments may be time consuming and require multiple visits to the office.
- \_\_\_ The treatments may be expensive.
- \_\_\_ The treated area(s) may develop new lesions.
- \_\_\_ The areas treated may have recurrence of previously treated lesions.
- \_\_\_ The treated area(s) may leave a scar(s).

**My signature below signifies my willingness to proceed with the therapy fully realizing the issues identified above.**

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

Patient Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

or

Name of Parent/Guardian if patient is a minor: \_\_\_\_\_

Signature of Parent/Guardian if patient is a minor: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_