Consent Form for Warts Removal.

I, _________________________ , was informed by Dr. Pivovarov that the diagnosis of warts has been made, specifically, the type of wart is called:

__ Planta warts, __ Genital warts, __ Flat, juvenile warts, __ Butcher's warts,

__ Heck's disease, oral warts, __ Molluscum Contagiosum, __ Verruca Vulgaris,

I was explained to my satisfaction the following: (Please initial each line)

___ There is no single treatment that can guarantee successful wart removal.

___ Wart removal may require several methods or treatment options.

___ Warts may recur and multiple treatments may be needed.

___ The treated area may heal with a scar.

___ Alternative treatments exist, such as salicylic acid applications, cryotherapy, laser therapy, Canhtaridin and podophyllin applications, Bleomycin injections, Dinitrochlorobenzene applications, Fluorouracil, Electrodesiccation, surgical curettage, Duct tape occlusion.

My signature below signifies I understand the nature of the procedure, risks and benefits, alternative methods or therapy; and, I am willing to proceed with fulguration procedure.

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 my insurance coverage. Any balance, after payment is made from the insurance carrier, such as co-pays, unmet deductible, or non-coverage althogether, is the responsibility of the patient or his guarator.

Patient/Guardian Signature _________________________ Date ____________

Witness Signature ________________________________ Date ____________