PEDIATRIC AND YOUNG ADULT MEDICINE

CONSENT FOR WART TREATMENT

LABEL

The above patient has been diagnosed with a wart/molluscum contagiosum.

I acknowledge that I have read the wart treatment sheet and am aware of the following:

- There is no single treatment that can guarantee successful treatment of warts
- Wart treatment may require one or more methods or combinations of several methods.
- Multiple treatments may be required.
- Treatment may require multiple office visits.
- The treatment may be expensive-**the in office treatment is a surgical procedure and billed accordingly.**
- All cost not covered by your insurance company is the responsibility of the guarantor.
- An office visit will only be charged for if you are seeing the provider for other evaluations and management of care not related to the wart treatment.
- The treated area(s) may develop new lesions.
- The treated area (s) may have recurrences of previously treated lesions.
- The treated area(s) may develop a scar.

The signature below represents the willingness to proceed with the procedure fully realizing the above statements.

- Any questions regarding cost may be discussed with our business office at 651-227-7806 Option 3

Since each insurance company has its own policies regarding the coverage of wart treatment, I acknowledge that the responsibility for payment in full for the charges incurred for wart treatment is the responsibility of the guarantor/parent responsible for the bill regardless of the coverage provided by the insurance company that insures the patient. Any balance after payment by the insurance company, such as co-payment, unmet deductible, or non-coverage, is the responsibility of the guarantor of the account.

Signature_____ Relationship_____

Date_____ Witness_____