

Patient Consent for Tattoo Removal

Patient Name _____ **Date** _____

I hereby authorize Advanced Skin Technologies, Dr. John T. Schroll, and his associates or licensees to perform the following treatment or procedure on my _____ as we have agreed upon: _____

I further authorize Advanced Skin Technologies, Dr. John T. Schroll, and his associates to do any other procedure that their judgment may dictate to be necessary or advisable should unforeseen circumstances arise during the operation. The details of the treatment or procedure have been explained in terms that I understand as well as alternative methods of treatment.

I am advised that though good results are expected, complications can occur and therefore there can be no guarantee, either expressed or implied as to the result of the treatment.

I have been advised and understand all potential complications and/or problems that may occur in this treatment and the healing period, and I understand them.

The doctor has offered to detail the less likely complications, even if rare could occur.

Please check one: I wish to have these described further to me
 I do not wish to have these described in further detail

I further consent to the administration of anesthetics if considered necessary. I recognize that there is always a risk to life associated with anesthesia and such risks have been fully explained to me.

Please check: I certify that I have read and understand this consent and that all blanks were filled in prior to my signature.

Patient or Legal Guardian/Representative Signature

Date

Witness

Relationship

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternative to the proposed procedure and have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

Physician Signature

Date