Feliz Care Centers

Procedure Authorization

I,_____ DOB:_____ authorize Feliz Care Center LLC and any provider acting as an agent thereof Feliz Care Centers LLC to perform the following operation or procedures.

◯ Wart/Lesion removal ◯ Other:_____

Alternative include: none

Risk: This authorization is given with the understanding that any operation or procedure involves some risk and hazards, some of the ***significant risks are cardiac failure, respiratory failure, and undesired cosmetic results***. More common risks of any procedure include infection, bleeding, nerve injury, blood clots, allergic reactions, and pneumonia. These risks are serious and possibly fatal.

Results not guaranteed: I understand that no guarantee or assurance has been made to the results of the procedure and that it may not cure the condition,

Parental Consent: I have read and fully understand this consent form, I comprehend that I should not sign this form if all items or questions have not been fully explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.

I understand that AHCCCS Programs do not cover the above procedure and that I am fully liable for the cost of the service. If I do not pay for the cost of the service the bill may go into collections. I have no further questions.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS AND OR HAZARDS OF THE PROPOSED PROCEADURE OR ANY QUESTIONS CONCERNING THEM, ASK YOUR HEALTH CARE PROVIDER BEFORE SIGNING THIS FORM.

Patient_____Date_____

Witness_____Date_____