Friendswood Dermatology

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WART TREATMENT CONSENT

This is to certify that the physician has explained to me that the diagnosis is of **(circle one)** **verruca vulgaris**, **molluscum contagiosum**, **genital warts/condyloma**, or _____ has been made. The physician has explained to my satisfaction to the following:

1. There is no guaranteed treatment method available for this condition.
    - Friendswood Dermatology offers the following types of wart treatments: Cantharone and Cantharone Plus (not FDA-approved), cryotherapy with liquid nitrogen, curettage, surgical procedure (electrofulguration), prescription for Wart Peel solution, and Mediplast.
    - If Cantharone or Cantharone Plus is used, the wart(s) will be covered with non-porous tape which should be removed by me after 1-2 hours then wash the treated area(s) with mild soap and water, dry off and protect with a loose Band-Aid.
2. **Multiple treatments may be required.**
3. The treatment may be time consuming and require multiple visits to the office.
4. The treatment may be expensive. **There is a charge each time I come into the office and have the wart(s) treated.**
5. **There is no guarantee that even after multiple treatments that the warts will be successfully treated.**
6. The treated area(s) may develop new lesions further complicating treatment.
7. The procedure may result in the following: pain, redness, bruising, swelling, blisters, open wound, infection, hypopigmentation, hyperpigmentation, and/or scarring.
8. Warts can disappear without treatment but can take months to years and can spread or become painful.

My signature below signifies my willingness to proceed with the therapy fully realizing the issues identified above. Since each insurance company has its own policy regarding the coverage of wart therapy, my signature further acknowledges that the responsibility for payment for all charges incurred for the wart therapy is my responsibility in full. If I am a patient or guardian of a patient who is enrolled in a managed care plan, I will be responsible for payment of any deductible and co-payments at the time of service.

_____ _____

Signature of Patient or Guardian (if patient is a minor) **Date**

_____

Print Name of Patient

_____

Signature of Witness