Shore Aesthetic & Reconstructive Associates
Roger A. Orsini, MD
505 Dutchmans Lane
Easton, MD 21601
410-822-7703

Patient Consent

______ I give my permission for the doctors and staff to treat me, including any biopsy or procedure(s), as deemed necessary in the exercise of their professional judgment.

______ I understand that medical care requires my cooperation, and I will follow my doctor's orders and prescriptions and if requested, will make and keep appointments for follow-up care and call the office to note any changes or concerns in my condition.

______ I authorize my physician to take photographs/video tape or by other similar means record my surgery/procedure(s).

______ I understand that reproduction or publication of these photographs and/or recordings, and/or documentation for my medical record may be used for the purpose of medical research, scientific study or patient education.

______ I understand that the photographs and recorded material may include appropriate portions of the body to demonstrate surgery/procedures(s) and that every effort will be made to protect the patient's identity in those materials.

______ I further acknowledge that all recorded media obtained is the sole property of my doctor.

______ I have read and understand the medical consent forms provided to me by my doctor's practice.

______ I authorize my doctor to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical care to third party payers, including Medicare.

______ I authorize and request that my insurance company pay to the doctor or medical group any benefits for services rendered, in lieu of reimbursing me directly.

______ I agree that I may be responsible for payment of all services rendered on my behalf or my dependents and understand that my medical insurance carrier may pay less than the actual bill for services.

______ I understand I may be billed by an outside laboratory for work that is performed in this office, if my insurance company does not have a contracted lab or facility, or if services are not covered by my insurance company.

____ ______________
(Print) Patient Name Date

____ ______________
Signature of patient or patient's legal guardian Date

My signature on this form authorizes Dr. __________________________ or__________________________ to perform the following procedure(s):

____ ____

____ ____

____ ____

______ I have been informed, to my satisfaction, regarding the nature of the procedure and as to why it is necessary.

______ I have been informed, to my satisfaction, regarding the risks inherent to the performance of any surgical procedure such as loss of blood, infection, reaction to anesthesia and the formation of thick or otherwise objectionable scars and I realize that such, or any, natural complications may result from the surgical procedure.

______ I give permission to have any tissue(s) removed during this procedure to be sent for histologic examination by a pathologist.

______ I have been informed, to my satisfaction, regarding the risks inherent to the performance of the procedure such as pain, swelling, redness, blister formation, discoloration, possible scarring and recurrence.

______ I have been informed, to my satisfaction, regarding the risks inherent to the performance of the procedure such as thinning of the skin, discoloration, atrophy, infection, possible scarring and recurrence.

______ I have been informed, to my satisfaction, regarding the risks inherent to the performance of the procedure such as weight gain, insomnia, swelling of the lower legs, increased blood sugar, increase in blood pressure, acne, cataract formation, avascular necrosis of the hip, thinning of the skin, and exacerbation of underlying infections or malignancy.

____ ______________
(Print) Patient Name Date

____ ______________
Signature of patient or patient's legal guardian Date