

DERMATOLOGY ASSOCIATES  
OF NORTHERN MICHIGAN, P.C.

**Biopsy, Electrodesiccation and Curettage (ED&C) & Cryosurgery Consent Form**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Date: \_\_\_\_\_

While under the care of Murray A. Cotter II, M.D. Ph.D, Lisa K. Bowersox, PA-C, Tina M. Crook, PA-C, or Deanna Geisler, PA-C, I consent to biopsy, ED&C, or cryosurgical procedures as recommended by the provider. In addition, we will also obtain verbal consent prior to performing any of the above procedures.

1. I understand that a biopsy requires obtaining a sample of tissue for diagnostic purposes and is a surgical procedure. I understand that this is a sample of tissue and may not remove the entire lesion and that additional procedures may be deemed necessary for complete treatment of the condition. I understand that ED&C may not remove the entire lesion and after pathology is reviewed, further treatment may be deemed necessary.
2. I understand that cryosurgery is destruction of tissue with liquid nitrogen. I understand that a sample of tissue is not submitted for pathology. Multiple treatments may be required to resolve all of a lesion(s).
3. I understand that all medical and surgical procedures involve some degree of risk. These risks include allergic reaction, bleeding, infection, blister or crust formation, injury to nerves or numbness, and scar formation; which may be thickened, depressed, keloid, or be lighter or darker than the color of the surrounding skin.
4. I authorize Dr. Cotter and his medical staff to administer local anesthetics as may be necessary or advisable by the provider responsible for this service.
5. I am aware that in the practice of medicine, other unexpected risks or complications not discussed may occur. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment. I understand that although the benefits are judged to outweigh the risks, if any of the previously mentioned complications occur they could be permanent.

I understand that all tissue samples will be sent for examination by a pathologist at an independent laboratory. You may receive a separate bill from the laboratory. Please contact the LAB with any billing questions.

I certify that I have read and understand the contents of this form. My signature below acknowledges that I voluntarily give my authorization and consent to the performance of the procedure(s) described above by my provider and/or his/her trained support staff.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

***If the patient is a minor and unable to give consent:***

Signature of person authorized to consent for patient: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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