Friendswood Dermatology

1111 Friendswood Drive #107
Friendswood, Tx 77546
281-482-3376

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, flat juvenile warts, genital warts, verruca plantaris, condylomata, 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.
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. **I will be charged each time I come into the office and have the warts treated.**
5. The treated area(s) may develop new lesions further complicating treatment.
6. The treated area(s) may leave a scar(s).
7. There is no guarantee that even after multiple treatments that the warts will be successfully treated.
8. Hypopigmentation, hyperpigmentation, or scarring may occur.

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 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.

Patient Signature/Guardian Signature (if patient is a minor)

_____	_____	_____
Print Name of Patient	Date	Signature of Witness

_____
Signature of Patient/Representative