

**Mounir Boutros, M.D.**  
**Renaissance Dermatology**

5951 Renaissance Place  
Toledo, Ohio 43623  
419-824-2288

**CONSENT FOR PROCEDURE**

Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

I authorize Dr. Mounir Boutros, Amy Bergan, PA-C, and their staff to perform the medical or surgical procedure listed below:

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They have discussed the following issues with me:

- Nature and purpose of the procedure.
- Risks of procedure including bleeding, scar formation, infection, and local anesthesia reaction. All these are infrequent and usually not very significant.
- Possible alternative methods of treatment.
- Other potential side effects (if applicable).

I understand that all removed tissue is routinely sent to a pathologist for examination, unless agreed otherwise, and that separate pathology fees will be charged.

I have had sufficient opportunity to discuss this procedure with them and all my questions have been answered to my satisfaction.

I also consent to photographing, if requested, my dermatology condition and/or this procedure for medical education purposes as long as my identity is not known.

If I have not received notification of results after one to two weeks, they are typically benign or insignificant, but I can call this office at the phone number noted above if desired.

Signature \_\_\_\_\_

Witness \_\_\_\_\_

Day Time Phone \_\_\_\_\_  
(for Biopsy results)

Relationship \_\_\_\_\_