

## **Montgomery Dermatology, LLC**

### ***General Consent for Evaluation and Treatment***

I allow the physician, Dr. Ilyas, to offer and provide treatment for my medical problem.

I acknowledge that treatment is dependent upon mutual interaction between patient and physician. I understand that it is my responsibility to not withhold intentionally or unintentionally knowledge of any medications by mouth I am currently taking or have taken in the past three months, including but not limited to prescription medications, over the counter medications, herbal supplements and remedies, vitamins, as well as illicit substances. I understand that it is also my responsibility to disclose both prior and current medical problems. If I do not disclose this information, I understand that the physician may not be able to provide optimal treatment and that withholding this information may result in unfavorable outcomes.

I understand that the treatment will not always correct my ailment and can even result in adverse complications. In addition, I understand that the best outcome requires the patient to diligently follow the prescribed treatment plan. Adverse outcomes can result from missing office appointments, not appropriately taking prescribed medications, and not following the treatment regimen in general as outlined by the physician.

Medications may be necessary in the treatment of your ailment. All medications have inherent risk of adverse complications. These include but are not limited to constipation, stomach upset, nausea/vomiting, and severe allergic reactions. In addition, the patient understands that severe cardio-pulmonary compromise, gastrointestinal bleeding, and/or death can occur if certain medications are taken while operating machinery, not taken as prescribed, taken with other substances (such as other narcotics, alcohol, or illicit drugs), or if taken by someone other than the person to whom it is prescribed. In addition, the patient is responsible for reviewing the details of the medication's adverse reactions as provided by the pharmacist.

I understand that for full skin examinations in routine surveillance for skin cancer that it is recommended that this exam be thorough. I understand that I reserve the right to defer examination of private areas. As skin cancer can occur on any part of the body, regardless of sun exposure, I understand that deferring examination in certain areas limits this examination. I also understand that skin examinations provide an analysis of the skin on the day of exam. Changes can occur at any time and that it is my responsibility to check my own skin on a monthly basis and follow up sooner if any

changes are noted. I understand that if a skin cancer is detected it does not necessarily mean it was present during a prior exam and it may have developed between examinations at any point in time.

I understand that in requesting treatment for acne that it is my responsibility to disclose if I am pregnant, planning pregnancy, nursing or not taking the necessary precautions to prevent a pregnancy. I understand that almost all acne treatments pose a potential risk to a developing fetus.

I understand that all procedures of every type carry inherent risks including but not limited to scarring, infection, bleeding, numbness, tingling, burning, blistering, allergic reactions to materials used, recurrence, or other adverse outcomes.

In conclusion, every effort should be taken by both the physician and patient from here forward in a spirit of joint cooperation to improve the patient's medical ailment. The patient acknowledges understanding the above possibilities of adverse complications of treatment and further understands that he/she is an active participant in the treatment of their ailment.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

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

Physician Signature: \_\_\_\_\_

ERUM ILYAS, M.D.