Dr. R. van Aardt
Cosmetic Medicine

MEDICAL PROCEDURE CONSENT

Name: _____	Date of Birth:_____
Health Card #:	Exp. Date:

Please Initial and sign below:

_____ I hereby consent to have Dr. _____
perform the following medical procedure:_____

I acknowledge that I have been fully informed of the following by my attending physician:

_____ The nature of my condition has been fully explained.
_____ I fully understand the nature and purpose of the procedure.
_____ I understand the explanation of risks involved with the procedure.
_____ I acknowledge that alternative treatments or procedures are available.
_____ The likely results of the procedure has been explained. procedure has been explained.
_____ I consent that before and after photographs will be taken of the procedure site if needed.

By signing below I hereby authorize the attending physician to proceed with the medical procedure required.

_____	_____	_____
Print Patient name	Signature of Patient or Guardian if under 18	Date
_____	_____	_____
Signature of Attending	Print name of Attending	Date

If you have any questions or concerns please contact the office.
902-893-7613