AUTHORIZATION FOR MEDICAL TREATMENT, ADMINISTATION OF ANESTHESIA AND THE PERFORMANCE OF OPERATIONS AND/OR PROCEDURES

1. I do hereby authorize the use of and the administration of such drugs, anesthetics, and other treatments and the performance of a skin biopsy and /or treatment with LN2 that has been deemed advisable, desirable, or necessary for diagnostic, therapeutic, or investigational purposes by Tory Sullivan, M.D./Edith Anidjar ARNP/ Heather Woolery-Lloyd, M.D. for or upon me or my dependent.

2. I further consent to the examination for diagnostic, investigational purposes, and disposal by authorities of the above named medical facility of any tissue or parts, which may be removed.

3. I understand that the skin biopsy involves removal of a piece of skin and that such removal may result in a permanent scar or in permanent discoloration of the skin at the site of the biopsy.

4. I understand that treatment of LN2 involves destruction of a piece of skin with liquid nitrogen and that such destruction may result in a permanent scar or in permanent discoloration of the skin at the site of the biopsy.

5. I understand that the above procedures may have some unwanted effects, which include, but are not limited to permanent scarring, discoloration of the skin, infection, bleeding, nerve damage resulting in temporary or permanent numbness or temporary or permanent loss of function of certain muscles (paralysis).

6. Specimens may be sent for dermatopathologic analysis at an outside laboratory. Charges for dermatopathology will be billed to insurance but in certain cases, individuals may be responsible for a portion or all of the charges.

7. I recognize the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.

8. I understand there are risks associated with a face-to- face visit during COVID-19 pandemic, Tory Sullivan MD PA has taken measures to reduce such risks, however, the risk associated with this contagious virus cannot be eliminated. The possibility of Covid19 infection, and quarantine and isolation measures that may be required following the face-to-face visit exist. Covid19 infection from an office visit can also result in serious infection and death. You have been informed that Telehealth visits are available to you but may not provide the same quality of care do to the limited examination available. The patient understands the risk of the face-to-face visit and has consented to proceed with the visit.

9. I HERBY ASSIGN to Tory Sullivan, M.D., P.A. all benefits provided under my healthcare plan or medical expense policy, including motor vehicle insurance, otherwise due or payable to me or on my behalf. All payments under this paragraph are to be made directly to such Assignee. I understand that I am personally responsible to this physician for charges not covered by this Assignment.

I ,_____, certify that I have read and fully understand the above consent and the explanations concerning the above items were made to me.

Signature_____Date_____

I,_____, have received (1) a copy of the Notice of the Privacy Practices or (2) have been offered a copy of the Notice of the Privacy Practices but declines to accept a copy.

Signature _____Date___ _____