Dr Neofytou Yiannis
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Βασιλέως Κωνσταντίνου 6, 8021
Πάφος
Τηλ/Φαξ: 26950303

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CONSENT FOR TREATMENT

I, _____, agree to the performance of _____at the anatomical site(s) of: _____ by my physician, **Dr Neofytou Yiannis.**

I understand that during the course of the procedure described above it may be necessary or appropriate to perform additional procedures that are unforeseen or not known to be needed at the time this consent is given. I consent to and authorize Dr. Neofytou Yiannis to make the decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures, as they deem necessary or appropriate.

The risks and benefits of the procedure have been explained to me. The risks include, but are not limited to: bleeding, infections, nerve damage, prominent scar that may require further surgery, post-operative pain, reaction to sutures, anesthetics, or topical antibiotics, skin necrotizing failure of the wound to heal and possible tumor recurrence. No guarantee or assurance of results can be made. Additional specific risks may include:

_____

I understand that there are certain medical and surgical alternatives available and I have been given information regarding other feasible forms of care.

I permit photographs of me to be taken for documentation, educational and teaching purposes during the course of my outpatient treatment. The photographs and information relating to my case may be published or used for any other professional purpose.

My signature below constitutes acknowledgement (1) that I have read and understand all of the above; (2) that all questions I have regarding my condition and the excision procedure have been answered to my satisfaction; (3) that the operation has been adequately explained by Dr. Neofytou or one of his assistants; (4) that I voluntarily, and knowingly give my signed authorization for this procedure.

_____ Signature of Patient

_____ Signature of Witness

_____Date and Time of Surgery