# Morris Jagodowicz, M.D.
# Pain Management
# Precision Injection Techniques

## COSMETIC CONSENT FORM

## AUTHORIZATION FOR AND CONSENT TO SPECIAL PROCEDURE USING CUTERA LASER

**Patient Name:_____**

1. Your attending physician is Dr._____Morris Jagodowicz_____
2. Dr.Jagodowicz maintains personnel and facilities to assist in his performance of various surgical and other special procedures. These procedures may all involve risks of unsuccessful results, complications such as burn injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to results. You have the right to be informed of such risks as well as the nature of the procedure, the expected benefits or effects of such procedure, and the available alternate methods of treatment and their risks and benefits. You also have the right to be informed whether your physician has any independent medical research or economic interests related to the performance of the proposed procedure. You have the right to consent to or to refuse any proposed procedure at any time prior to its performance.
3. Your physician has recommended the following procedure:
   _____
4. Upon your authorization and consent, this procedure, together with any different or further procedures, which in the opinion of the physician may be indicated due to any emergency, will be performed on you. The physician named above will perform the procedure
5. To make sure that you fully understand the procedure, your physician will fully explain the The procedure to you before you decide whether or not to give consent. If you have any questions, you are encouraged and expected to ask them.
6. Your signature on this form indicates (1) that you have read and understood the information Provided in this form, (2) that the procedure set forth above has been adequately explained to you by your physician, (3) that you have had a chance to ask questions, (4) that you have received all of the information you desire concerning the procedure, (5) that you are responsible for payment for this procedure, and (6) that you authorize and consent to the performance of the procedure.

**Date:_____ Signature of Patient:_____**