assuredimaging
Skin Cancer Screenings

MRN _____

Last Name	First Name	MI	DOB	Age	Sex
					☐ F ☐ M

SKIN CANCER SCREENING CONSENT & RELEASE FORM

I, _____ understand that:
Patient/Guardian

This exam is a screening test, it cannot, nor is it intended to, detect all diseases. If I have any questions about the appropriateness of this for test me, I agree to consult my own personal physician.

The data derived from this screening test **does not** constitute a diagnosis of disease.

If the results from this screening suggest that I contact a physician for further evaluation, it is my sole responsibility to contact a medical professional of my choosing for follow-up care.

☐ I hereby consent to the performance of comprehensive skin cancer screening by Assured Imaging for the purpose of evaluating for the presence of detectable abnormalities.

☐ I hereby release and agree to hold harmless, Assured Imaging, LLC from any and all liability arising from or related to, or in any way connected with this screening, or from the data derived therefrom.

☐ I give consent and authorization for my results to be released to my Primary Care Physician for tracking purposes and follow up on the abnormal results.

Patient/Guardian signature: _____ Date: _____

☐ **CONSENT FOR LIQUID NITROGEN TREATMENT *(if available)***

- I understand there is no guarantee that the liquid nitrogen treatment (LN) will cure or eradicate the condition or lesion treated. The treatment may need to be repeated and sometimes more aggressive treatment modalities are necessary if LN treatment fails. Treatment may leave a white or brown mark, and occasionally, a scar. I understand that I should follow up with my provider if the treated area does not resolve.
- The procedure and its purpose have been explained to me. I have been given a chance to ask questions regarding the treatment and fully understand the treatment and its potential risks.
- I consent to liquid nitrogen treatment for my current skin problem as recommended by my provider at Assured Imaging.
- I understand that this procedure may be applied to my surgical deductible.
- I have read and understand all of the above.

Patient/Guardian signature: _____ Date: _____