Carson Medical Group
Consent for Medical Ear-Piercing

Patient Name _____ Date of Birth _____

PLEASE INITIAL FOR CONSENT:

_____ I understand that fees for ear piercing will not be filed against any insurance. All payment for this service is due at the time of the visit.

_____ I understand the patient's ears will be pierced with pre-sterilized, single use, medical grade plastic or titanium earrings.

_____ I acknowledge that if the patient has a bleeding disorder, diabetes, high blood pressure, immune disorder, heart condition, allergies, or a skin disorder, then ear piercing may carry a greater risk for my child.

_____ I understand that ear-piercing is a minor surgical procedure with similar risks to stitches or abscess drainage. Despite all precautions that are taken by Carson Medical Group and my proper aftercare treatment, the potential for infection still exists. There is also the potential that one of the following complications may occur as a result of ear piercing:

Persistent redness
Drainage from piercing
Embedded clasp
Bacterial infection of the blood (septicemia)
Traumatic injury
Abnormal healing of the ear, such as keloid scarring or cauliflower ear
Swelling
Bleeding from piercing
Local would infection/cellulitis
Pressure Sore

** Please contact Carson Medical Group if the patient experiences any of these symptoms.

_____ I read and understand the AFTERCARE INSTRUCTIONS and have received a copy for my reference. Aftercare of piercing is the responsibility of the parent or patient, once they leave the office.

_____ I agree that if at any time it is deemed unsafe for the patient or the medical staff to continue with the procedure, then the procedure will be stopped and potentially rescheduled for another time.

_____ I understand the importance of a follow-up nurse only visit to Carson Medical Group two weeks after the ear-piercing procedure to check for proper healing and signs of infection. I will make and keep this appointment. (Cost of follow-up visit included in ear-piercing fee).

_____ I have agreed to this ear-piercing procedure and I am fully aware of the potential risks and complications of the procedure.

I have read and understand all the items listed above and I agree to their terms. By signing this document, I certify to Carson Medical Group that I am the parent or legal guardian of the minor patient named above, or I am eighteen years or older and able to consent for my own procedures.

Signature _____ Date _____

Print Name _____ Relationship to Patient: _____

Witness Signature _____ Date _____