ATLANTA PEDIATRIC PARTNERS, P.C.
EAR PIERCING POLICY

Atlanta Pediatric Partners, P.C. offers ear piercing to our female patients age 10 weeks and older who show proof of having received at least one tetnus immunization in the past. The cost of the procedure is $40.00 payable at time of the visit.

Informed Consent to Treatment

Patient's Name: _____

Date of Birth: _____

Diagnosis: Unpierced ears

Procedure(s): ____Right ___Left ___Not applicable
Ear Piercing.

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1. In conjunction with the procedure(s) identified above, I understand the following:
   a. NATURE AND PURPOSE OF PROCEDURE (describe in layman's terms): To pierce using 24K Gold plated studs.
   b. MATERIALS RISKS OF PROEDURE: allergic reaction, infection, cardiac arrest, disfiguring scars, loss or loss function of any limb or organ, severe loss of blood or death.

   Other risks of the procedure(s) are:
   Infection, Blood Loss, Total ear lobe laceration, Keloid formation. In order to reduce the risk of infection, we recommend that you follow the cleaning guidelines given to you to help prevent risk of infection or premature closure of the pierced site. The earrings should not be removed for the first 30 days secondary to of closure of the site. The earlobes need to be cleaned as directed every day with alcohol to reduce the risk of infection. Pleas notify our office immediately of any redness, pus, or drainage from the pierced site.

   c. LIKELIHOOD OF SUCCESS: X GOOD __FAIR __POOR __OTHER
   d. PRACTICAL ALTERNATIVES TO PROCEDURE(S): Unpierced ears.
   e. PROGNOSIS IF CONSENT REFUSED: X GOOD __FAIR __ POOR __ OTHER
2. The procedure identified above has been explained to me and all of my questions have been answered. I acknowledge that no guarantees have been made concerning the outcome of the procedure. I hereby consent to the performance of this procedure by _____(Nurse/Medical Assistant (MA) or Physician employed by Atlanta Pediatric Partners, P.C.) and for all other medical personnel otherwise involved in the course of treatment.

3. I realize that, during the procedure, the physician/nurse/MA may become aware of conditions that were not apparent before the start of the procedure. I therefore, consent to any additional or different procedures the physician/nurse/MA considers necessary or appropriate to treat, cure or diagnose conditions which may be unknown or unforeseen at the time this consent is obtained.

4. If acceptable to the physician/nurse/MA and Atlanta Pediatric Partners' Policies, I authorize observers to be present during procedure.

5. I understand that the physician, medical personnel and the other assistants will rely on statements about the patient, the patient's medical history and other information in determining whether to perform the procedure or the course of the treatment for the patient's condition and recommending the procedure which has been explained.

6. I understand that the practice of medicine is not an exact science and that no guarantees or assurances have been made to me concerning the results of this procedure and that sometimes a patient's expectations may be greater than the actual outcome of the treatment.

7. I acknowledge and understand that the explanation that I have received may not be exhaustive and all-inclusive and that other more remote risks may be involved. However, the information that I have received is sufficient for me to authorize and consent to procedure I have authorized as my own free act.

SIGNATURE OF CONSENTING PERSON

RELATIONSHIP OF CONSENTING PERSON TO PATIENT

DATE TIME

WITNESS

DATE TIME

(Required when: 1. Verifying consent of an authorizing person who cannot make their own signature or mark, or 2. Consent is obtained by telephone.

I have discussed the risks, benefits, and alternatives of the procedure with the individual giving consent.

SIGNATURE OF PHYSICIAN/NURSE/MA

DATE TIME