Frederick Pediatric Associates

Ear Piercing Consent Form

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. A non-refundable deposit of $50 is included in the fee.

_____ I understand the patient's ears will be pierced with pre-sterilized, single use, hypoallergenic earrings using the Coren Preloaded Ear Piercing System.

_____ I understand that the patient must be up-to-date with vaccines and have received at least the first set of immunizations according to the CDC Vaccine Schedule. Latest DTaP/Tdap date: _____

_____ 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 Frederick Pediatric Associates 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	Swelling	Bleeding or Drainage from piercing
Embedded clasp	Pressure Sore	Local wound infection/cellulitis
Bacterial infection of the blood	Traumatic injury	Abnormal healing of the ear

** Please contact Frederick Pediatric Associates 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 and is not monitored by Frederick Pediatric Associates.

_____ 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 that I will be given the opportunity to view the proposed piercing location on the earlobe and verbally consent prior to placement of the earrings.

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

_____ I understand post-surgical complications are not covered by the initial fee. If they require a medical appointment, this will be subject to your insurance. Billing, coinsurance and copay will apply.

I have read and understand all the items listed above and agree to their terms. By signing this document, I certify to Frederick Pediatric Associates 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:_____