1200 Airport Heights Drive Suite 140
Anchorage, Alaska 99508
907.777.1800
www.akpeds.com

Earlobe Piercing Consent Form

Patient Info

First Name: | Middle: | Last: | Suffix:

Address: | City: | State: | Zip:

Date of Birth: _____ / _____ / _____ | Sex: M / F

How did you find out about ACP? ☐ friend or referral - please list: ____
☐ internet search ☐ advertisement ☐ insurance company ☐ yellow pages

Guardian Contact Info

Name: | Phone: | Relationship to Patient:

Medical History

Please check if you have history of any of the following conditions: ❑ Diabetes ❑ Hemophilia
❑ Development of Keloid Scars ❑ Auto-immune ❑ Heart conditions ❑ Skin conditions

Please list any other health concerns you may have that may adversely affect your procedure today:

ACP Policy and Procedure Consent Acknowledgement

***HIPAA Privacy Rule (Consent, Information Disclosures and Authorization)**

All information provided by the patient is deemed private under the Health Insurance Portability and Accountability Act (HIPAA) and will be used only with patient consent. I hereby authorize Alaska Center for Pediatrics, P.C. to furnish information to other providers, healthcare or treatment facilities. I understand that the information to be released MAY include material that is protected by Federal Law.

***Check-in Policies** - in our effort to provide excellent care and service to our patients, we request that you observe the following policies:

- Patient contact information and identification (when appropriate) will be verified at each visit
- No cell phone use in exam rooms
- All patients are expected to check out with the front desk after each visit
- A medical claim will not be created for this visit. A $50 fee will be collected prior to your procedure.

***Please initial for consent**

___I understand that my ears will be pierced with pre-sterilized, single use ear piercing earrings.

___I acknowledge that if I am taking blood-thinning medications, antibiotics, am diabetic, pregnant, have a history of infection or any other medical problems, that ear piercing may carry a greater risk for me.

___I understand that, despite ACP's best efforts and my proper following of aftercare, the potential for infection exists. Improper after care or hygiene, metal sensitivity, or other causes my increase the risk of infection. Ear piercing may result in the formation of cysts or keloids.

___I have read, and understand the AFTER CARE PROCEDURES and have received a copy for my reference. I understand that after care is solely my responsibility and that ACP will not monitor it.

___I have agreed to this ear piercing procedure, and am fully aware of the potential risks and complications.

As the primary guardian for this patient, I have read and understand all of the office policies listed above and agree to their terms.

***Signature of Responsible Party ______________________________________Date: ___________________________**

ACP staff initials:	Date:	ACP staff initials:	Date: