CONSENT FOR CHEMICAL MATRIXECTOMY\ NAIL AVULSION PROCEDURE

Patient ________________________  Date_______________________

I hereby authorized Central Kansas Podiatry to treat the condition or conditions that have been diagnosed, and
to perform the following operation or procedure:

Permanent removal of the lateral medial bilateral border/s of the
1st 2nd 3rd 4th 5th toe/s right left foot using phenol/ NaOH. Temporary Avulsion

The nature of this operation or procedure has been explained to me by my physician and I have been informed
of the risks involved therein, (including but not limited to) the risk of unusual blood loss, infection, heart
irregularity, shock and death that are attendant to the performance of any surgical procedure. Other potential
complications of the above procedures include but are not limited to: possible pain, numbness, swelling,
discoloration, **possible infection, or possible regrowth**.

I AM ALSO AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT
SCIENCE AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME
CONCERNING THE RESULTS OF THE OPERATION OR PROCEDURE.

I further authorize the performance of such other procedures, in which the said physician may deem advisable at
the time of or during surgery, and I authorized the use and disposition of any tissues removed for diagnostic or
scientific purposes.

I have been instructed and understand post-operative home care instructions.
________ (patient/parent/responsible party or guardian’s initials)

_____________________________ or ______________________________
Patient Signature        Parent/Responsible Party/Guardian

_____________________________
Witness