# CENTENNIAL PEDIATRICS

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## DISCLOSURE AND CONSENT FOR EAR PIERCING

**Patient Name:** _____ **Date of Birth:** _____

_____ **Ear Piercing Cost-$85.00 (Both Ears)**
**This includes the piercing studs that are removed after 6-8 weeks, and a permanent pair of hypoallergenic earrings.**

_____ **Ear Piercing Cost-$100.00 (Both Ears)**
**This includes the piercing studs that are removed after 6-8 weeks, a permanent pair of hypoallergenic earrings, and a local anesthetic applied to the ears 30 minutes prior to ear piercing to reduce the discomfort associated with ear piercing.**

_____ **Ear Piercing Cost-$60.00 (Single Ear)**
**This includes the piercing stud that is removed after 6-8 weeks, and a permanent pair of hypoallergenic earrings.**

**PLEASE INITIAL FOR CONSENT:**

_____ I (we) voluntarily request that Centennial Pediatrics, P.A. as my child's physicians, and such associates or assistants and other health care providers as he/she deem necessary perform the following procedure: **Ear Piercing**

_____ I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for your child and I (we) voluntarily consent and authorize these procedures: **Ear Piercing**

_____ I (we) understand that the fees for ear piercing will not be filed against my insurance. All payments for this service are due at the time of the visit.

_____ I (we) understand that my child's ears will be pierced with pre-sterilized, single use, medical grade plastic or titanium earrings.

_____ I (we) acknowledge that if my child 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 (we) have read and understand the AFTER CARE INSTRUCTIONS and have received a copy for my reference. Aftercare of piercing is the responsibility of the parent or patient, once they leave this office.

_____ I (we) agree that if at any time, it is deemed unsafe for my child or the medical staff to continue with the procedure, then the procedure will be stopped and potentially rescheduled for another time. Refunds are available for cancelled appointments if the pre-sterilized earrings have not been opened.

_____ I (we) understand that Ear Piercing is a minor surgical procedure with similar risks to stitches or abscess drainage. Despite all precautions that are taken by Centennial Pediatrics and proper aftercare treatment, there are also risks and hazards related to the performance of the procedure planned for your child. I (we) realize that common to surgical, medical and/or diagnostic procedures is the potential for pain, bleeding, infection, allergic reactions and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure:

_____ Persistent redness or swelling, drainage or bleeding from the piercing, embedded clasp, local wound infection/cellulitis, bacterial infection of the blood (septicemia), abnormal healing of the ear such as keloid scarring or cauliflower ear, pressure sore, traumatic injury, poor cosmetic result, or need for additional procedures

_____ I (we) understand that after approximately 6 weeks, the ear piercing earrings need to be removed permanently and changed to new earrings.

_____ I (we) have been given the opportunity to ask questions about my child's condition, alternative forms of treatment, risk of non-treatment, the procedures to be used and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

**By signing this document, I (we) certify this form has been fully explained to me, that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents. I (we) certify to Centennial Pediatrics that I (we) am the parent or legal guardian of the minor patient named above or I am eighteen years of age or older and able to consent for my own procedures.**

_____ _____
**Parent or Guardian Printed Name** **Date & Time**

_____ _____
**Parent or Guardian Signature** **Relationship to Child or Self**

_____ _____
**Physician/Witness Signature** **Physician/Witness Name and Date**