MR#:_____

DermOne™
Dermatology, Cosmetic
& Scarless Vein Center

KAMRAN GOUDARZI, MD
MICHAEL CAHN, MD
Phone: (910) 798-5347
Fax: (910) 798-4951
Accredited Vascular Laboratory

PHYSICIAN DISCLOSURE

Patient Name: _____ DOB: _____

I understand that DermOne Dermatology, Cosmetic & Scarless Vein Center has two (2) surgeons that provide patient care for the treatment of venous disease.

I hereby acknowledge that **it is my choice** to be treated at the following location: (circle one)

Mayfaire Office by Kamran Goudarzi, MD for all of my treatments

Shallotte Office by Michael Cahn, MD for all of my treatments

I hereby acknowledge that **it is my choice** to be treated by either **Kamran Goudarzi, MD ONLY or Michael Cahn, MD ONLY**.

Patient to complete the following in their handwriting:

It is my choice that I will be treated by _____, MD at the _____ location.

I HAVE READ AND HEREBY ACKNOWLEDGE UNDERSTANDING OF THE ABOVE DISCLOSURE.

_____

Patient's Signature/Legal Guardian's Signature, if indicated Date

Reviewed with Patient by: _____, RN
(Name of Registered Nurse)

_____

RN's Signature Date