Consent form for Cryotherapy

I ..... give my free and full consent to Dr .... for the purpose of cryotherapy for ..... with / without local anesthesia/anxiolytic/NSAID, the nature and consequences of which have been explained to me. I have been completley explained the technique, its results and possible side-effects such as blistering, pigmentary changes. I understand that more than one session may be needed for complete results. I understand the limitation of the procedure and also the final results. I have been provided adequate opportunity to seek information during personal consultation and also through brochures.

Signature of patient /-

Signature of Doctor /-

Signature of witness /-