CASTLE ROCK
PEDIATRICS

Ear Piercing Consent Form

Patient Name: _____ DOB: _____

_____ Ear Piercing, Medical Grade Plastic or Titanium Earrings - $100

_____ Add numbing cream – additional $15

PLEASE INITIAL FOR CONSENT:

_____ I voluntarily request that Castle Rock Pediatrics, PLLC perform the following procedure: Ear Piercing

_____ I understand the fee for ear piercing is due at time of service and will not be filed to my health insurance company.

_____ I understand that my child's ears will be pierced with pre-sterilized, single-use medical grade hypoallergenic earrings.

_____ I agree that my child is at least 4 months old and is up to date on DTaP/Tdap vaccinations, with a minimum of two DTaPs.

_____ I acknowledge that if my child is taking blood thinning medications, antibiotics, steroids, or antihistamines, ear piercing may carry a greater risk.

_____ I acknowledge that ear piercing is a minor surgical procedure. Despite all precautions that are taken by Castle Rock Pediatrics, PLLC and my proper following of aftercare, the potential for complication still exists. Although rare, any of the following complications can occur because of ear piercing: persistent redness, swelling, drainage, bleeding, embedded clasp, local infection, cellulitis, keloids. I agree to contact the practice if I experience any of these.

_____ I acknowledge that dissatisfaction with earring location is possible. I understand the provider will allow me to confirm placement prior to the procedure; however, if I am unhappy with the final placement, I will remove the earring and return for a free re-pierce once healed (2-4 weeks). I understand that I will not receive a refund due to placement.

_____ I acknowledge that my child must be able to remain calm and still during the procedure. I understand that clinical staff reserve the right to cancel the procedure if they feel, for any reason, that the situation may be unsafe due to a child's unwillingness to cooperate.

_____ I have read and understand the AFTERCARE INSTRUCTIONS and have received a copy for my reference. I understand that aftercare of piercing is the responsibility of the patient or parent once they leave the office.

_____ I have agreed to this ear-piercing procedure and am fully aware of the potential risks and complications.

I have read and understand all of the items listed above and agree to their terms. If the patient is a minor, then the undersigned certifies to Castle Rock Pediatrics, PLLC that the undersigned is a parent or legal guardian of the minor patient named above.

_____ _____

Printed Name Date

_____

Signature