WAYNE NEUROLOGY, PLC

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CONSENT FOR SKIN BIOPSY

I hereby request and authorize _____, and/or his/her associates and assistants of his/her choice to perform the skin biopsy on: _____(patient).

☐ I understand that this procedure has risks which may include:
- Scarring (which may be permanent)
- Pain
- Bleeding
- Infection
- Allergy to latex
- Allergy to local anesthetic

☐ I have had an opportunity to ask questions regarding this procedure and have received answers, and have received sufficient information so that I understand:
- My current medical condition
- The nature of the procedure
- The risks and benefits of the procedure
- The prognosis of my condition with/without the procedure
- The post-biopsy procedure

☐ Based upon my discussion with my physician and the information I have received, I give my consent to the procedure. I understand that the practice of medicine is not an exact science and no guarantees have been made concerning the results of the procedure.

☐ I authorize my clinician's office to obtain and provide CND Life Sciences with all the necessary information required for the purposes of receiving payment for alpha-synuclein testing services. CND Life Sciences may contact me via phone, email, text message, and letter regarding payment for services.

☐ I confirm that I have read this form, or that it was read to me, that all my questions have been answered, that all blank spaces were filled in and all sections that do not apply were crossed out before I signed below:

_____ _____

Patient Signature (or authorized patient representative) Date

_____

Patient Name (Print) (or authorized patient representative)