EAR PIERCING CONSENT

Patient Name:_____
Date of birth: _____
Please review and initial to indicate consent:

____ I understand that fees for ear piercing will not be filed with my insurance. All payments for this service are due in full at the time of scheduling.

____ I understand that the patient must be up to date on their well child exams and routine vaccines. Infants must have received at least the first set of immunizations according to the CDC Vaccine Schedule.

____ I understand that my child's ears will be pierced with pre-sterilized, single-use cartridges with hypoallergenic ear-studs manufactured by Blomdahl.

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

____ I attest that to the best of my knowledge, my child does not have high blood pressure, epilepsy, hemophilia or other bleeding disorders, a heart condition, or is pregnant.

____ I understand that ear piercing is a minor surgical procedure with similar risks to stitches and abscess drainage. Despite all precautions taken by Pediatric and Adolescent Specialists of Rockwall and my proper following of aftercare instructions, the potential for infection still exists. There is also potential that one of the following complications may occur as a result of ear piercing:

Persistent redness	Swelling	Drainage	Bleeding
Embedded clasp	Local infection	Cellulitis	Blood poisoning
Keloids	Cauliflower ear	Pressure sore	Traumatic injury

*** Please contact Pediatric and Adolescent Specialists of Rockwall if any of these occur or are suspected to have occurred ***

____ I have read and understand the **aftercare instructions** and have received a copy for my reference. I understand that aftercare is the sole responsibility of the patient/parent/caregiver once leaving the office.

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

____ I agree that if at any time it is deemed unsafe for the patient or medical staff to continue with the procedure, then the procedure will be immediately stopped and potentially rescheduled for another time.

____ I understand post-surgical complications are not covered by the initial fee. If they require a medical appointment, this will be subject to your insurance. Billing, coinsurance and copay will apply.

I have read and understood all items listed above and agree to their terms. If the patient is a minor, then the undersigned certifies to Pediatric and Adolescent Specialists of Rockwall that the undersigned is the parent or legal guardian of the minor patient named above.

To be completed at time of piercing:

____ **I attest that I have confirmed placement of the ear piercing and am satisfied with the position. I am aware that the integrity of the piercing is priority, and thus symmetry of the piercing may be affected.**

Signature: _____ Date: _____
Print Name: _____ Relationship to Patient: _____

Rev 2024