NORTH SEATTLE DENTAL

Consent for
VELscope Oral Cancer
Examination

Patient Name: _____

1. The purpose of this screening examination for oral cancer with the Visually Enhanced Lesion Scope (VELscope) has been explained to me. This is in addition to the current visual oral exam.
2. I understand that this is an elective procedure and that this test is only a screening test. I understand that a perfect result is not guaranteed or warranted, and that if needed, follow up treatment by another specialist may be required.
3. I authorize Christopher Pickel, D.D.S., Leah Worstman, D.D.S. and any associates to perform the Visually Enhanced Lesion Scope (VELscope) oral cancer examination.
4. At the present time, the VELscope exam is not a covered benefit by insurance companies. The fee is $35.

Please circle to either accept or decline this service at today's visit.

ACCEPT DECLINE

Patient Signature:_____Date:_____