

Informed Consent For Cosmetic Procedures

Name of patient _____ Date _____

I hereby request and authorize Dr. _____, aided by any assistants he/she may require, to perform _____ on or about the ____ day of _____ for the purpose of attempting to improve _____ appearance with respect to the following conditions _____

Dr. _____ has fully explained, in terms clear to me, the effects and nature of the procedure(s) to be performed, foreseeable risks involved, and alternative methods of treatment. Lastly, I have been given the opportunity to ask any questions regarding the matters covered in the preceding two sentences, and these questions have been answered to my satisfaction. I also authorize the operating surgeon to perform any other procedures which he/she may deem necessary or desirable in attempting to improve the condition stated in paragraph one or to treat any unforeseen condition or complication that she/he may encounter during the operation. I consent to the administration of anesthetics by or under the direction of Dr. _____ and to the use of such anesthetics and medications as he/she may deem advisable in my case.

I have been advised that the goal of the procedure I have requested is improvement in the appearance, not perfection, that there is a possibility that imperfections might ensue, and that the results might not meet my expectations or the goals that have been established. In relation to this I know that the practice of medicine and surgery is not an exact science and that, therefore, no guarantee or assurance has been made by anyone regarding the procedure which I have herein requested and authorized.

I understand that if Dr. _____ judges at any time that my procedure should be postponed or canceled for any reason, she/he may do so.

I hereby state that the information furnished to Dr. _____ during my diagnostic evaluation is correct.

I agree to follow the instructions given to me by Dr. _____ to the best of my ability before, during and after the above named procedure(s).

Signature _____ Date _____
(Patient or person authorized to give consent for the patient)

Witness _____ Date _____

Physician _____ Date _____