



FACIAL PLASTIC &

RECONSTRUCTIVE SURGERY

Michael C. Neuenschwander, MD

Informed Consent for Treatment with Injectable Fillers And/or Implants for Facial Rhytids (Wrinkles)

TO THE PATIENT

You have the right, as our patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I voluntarily request Dr. Michael Neuenschwander as my physician, and such associates, technical assistants and other health care providers as he may deem necessary, to treat my condition which has been explained to me as:

Skin changes or deformities related to aging, sun exposure, scarring, pigmentation, rhytids, or excessive skin

Facial rhytids (wrinkles), deep furrows or folds including, but not limited to fine wrinkles, forehead lines, crow's feet, frown lines, nasolabial folds, chin lines, and lip lines

I understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I voluntarily consent and authorize these procedures:

- _____ Use of injectable fillers (Hyaluronic acid, collagen, fat)
- _____ Use of a tissue implant (Alloderm, Surgisis)
- _____ Use of a synthetic implant (Goretex, Softform, Ultraform, Silastic, Medpor)
- _____ Other filler/implant _____

Many of these materials have not been FDA approved for the stated use. These materials have been used previously for these conditions, have been used by others for these conditions, are used in other countries such as Canada or Europe for these conditions, are used for other unrelated conditions, or are so new that there is not enough information or experience with them as fillers or implants. This will be discussed with you.

I understand that Dr. Neuenschwander may discover other or different conditions which require additional or different procedures than those planned. I authorize Dr. Neuenschwander, and such associates, technical assistants, and other health care providers to perform such other procedures, which are advisable in their professional judgment.

I understand that no warranty or guarantee has been made as to result or cure.

RISKS AND HAZARDS

Just as there are risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical and/or diagnostic procedures planned for me. I realize that common to surgical, medical and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I also realize that the following risks and hazards may occur in conjunction with this particular procedure, and that other risks not known or listed may occur.

- Worsening or unsatisfactory cosmetic appearance or permanent deformity
- Persistence, recurrence, or worsening of skin changes and wrinkles
- Resorption of filler or implant
- Rejection of implant resulting in infection and possible removal
- Telangiectasia (small blood vessels), milia (blocked pores)
- Poor healing or skin loss with painful or unattractive scarring
- Hypo- or hyperpigmentation
- Impairment of regional organs such as lip or eye function
- Necessity for additional procedures, expense, and time off work

Patient or Authorized Representative

Date

Time

I have thoroughly and completely been advised regarding the objectives of this procedure. Since I understand that the practice of medicine and surgery is not an exact science and therefore no reputable surgeon can guarantee results, I acknowledge that imperfections might ensue and that the operative result may not live up to my expectations. I certify that no guarantees have been made by anyone regarding the operations I have requested and authorized.

I understand that anesthesia involves additional risks and hazards, but I request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I realize that the type of anesthesia may have to be changed without explanation to me.

RECOGNITION

I understand that if Dr. Neuenschwander judges at any time that my surgery should be postponed or cancelled for any reason, he may do so.

I consent to the admittance of authorized observers to the operating room for the purpose of advancing medical education.

I give permission to Dr. Neuenschwander to take still, digital, or motion photographs with the understanding that such photographs remain the property of the doctor.

I have read completely Dr. Neuenschwander's information sheets on implants and fillers. I understand all of the information contained in the sheets, and have had an opportunity to discuss and ask questions about this information.

I have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.

I certify that this form has been thoroughly explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.

Patient or Authorized Representative

Date

Time

Physician Obtaining Consent

Witness