THE NADERI CENTER
PLASTIC SURGERY & DERMATOLOGY

PATIENT NAME:

DOB:

CONSENT FOR SURGERY / PROCEDURE or TREATMENT(s)

I hereby authorize to perform the following procedure(s) or treatment(s):

SAMPLE CONSENT: FINALIZED PROCEDURE DESCRIPTION TO BE DETERMINED AT PREOP APPOINTMENT **and all indicated procedures.**

1. I recognize that during the course of the operation, medical treatment and anesthesia, unforeseen conditions may necessitate different and/or additional procedures than those above. I therefore authorize the above physicians to perform such other procedures that are in the exercise of his/her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician at the time the procedure is begun or necessary in his/her opinion for satisfactory outcome.
2. I understand the surgery is performed only by my surgeon but assistants may be necessary for the procedure.
3. I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involve risk and the possibility of complications including injury, dental &/or Oropharyngolaryngeal trauma, cardiopulmonary event, stroke and sometimes death.
4. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained and results vary depending on multiple factors including intra-operative factors and post-operative healing.
5. I understand that despite my surgeon's best effort, I may not end up with the expected result.
6. I understand the goal of my elective surgery is significant improvement but that "perfect" results are subjective and unrealistic.
7. I understand that swelling and bruising are expected. These may be prolonged or permanent. Healing may takes months to years.
8. I understand scars and scar tissue are a normal part of surgery and healing and may sometimes create undesirable results. I understand that the healing process is different for each patient and is out of the doctor's control.
9. I understand common risks include but are not limited to bleeding, infection, damage to surrounding structures or deeper structures, scarring, distortion &/or asymmetry, wound separation, delayed healing, pain, numbness, tingling, allergic reactions, anesthesia complications, tightness of the area, sagging, lumps and bumps, contour irregularities, color changes, nerve damage (motor &/or sensory), blood vessel trauma, fluid collections (hematoma, seroma, abscess), life threatening events (heart attack, stroke, embolism, blood clots, meningitis, CSF leak), changes in taste, smell, voice &/or swallowing, change in vision, excess tearing or dry eyes, runny or dry nose, oily or dry skin, distortion of normal anatomy, skin loss or necrosis, fistula, death, and need for further procedures or surgeries.
10. I consent to the photographing or Videotaping of the operation(s) or procedure(s) to be performed provided my name is not revealed by the images.
11. I consent to the admittance of observers to the operating room who may only watch to learn from my surgeon.
12. I consent to the disposal of any tissue medical devices which may be removed.
13. I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical-device registration and billing if applicable.
14. I agree to discuss my concerns with doctors and staff at The Naderi Center rather than through online reviews.
15. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
    a. THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN
    b. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
    c. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

I CONSENT TO THE TREATMENT OR PROCEDURE AND ABOVE LISTED ITEMS (1-16). I REQUESTED AND RECEIVED, IN SUBSTANTIAL DETAIL, FURTHER EXPLANATION OF THE PROCEDURE OR TREATMENT, OTHER ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT AND INFORMATION ABOUT THE MATERIAL RIAL RISKS OF THE PROCEDURE OR TREATMENT.

FOR REVIEW ONLY - PATIENT WILL SIGN DAY OF SURGERY

Patient (or legal guardian) Print

Patient (or legal guardian) Sign Date

Surgeon Sign Witness Sign Date

THE NADERI CENTER
PLASTIC SURGERY & DERMATOLOGY

PATIENT NAME: _____

DOB:

FINANCIAL POLICY REGARDING REVISION AND COMPLICATIONS

Every surgery has a potential for a few patients who will require revision or have some unforeseen complications requiring additional surgery. No surgeon can guarantee the results or happiness. In cosmetic procedures there are certain problems that will happen statistically, no matter how great the care or how skilled the doctor and team. Some examples of problems that may be encountered are bleeding, infection, unfavorable healing or scarring after a surgical procedure. In such cases, it may be necessary to return the patient to surgery, either on an emergency basis (as in the case with bleeding) or an elective basis (as in the case of poor healing).

The vast majority of patients do not require additional surgery and do not have complications and as long as they have realistic expectations and understand that perfection is impossible, no revision surgery is necessary. However, no surgeon can guarantee this to patients. It is important for the patient undergoing an elective surgical procedure to understand this reality, risk and financial obligation and policy.

Patients are responsible and are expected to pay any and all associated expenses that arise as a result of treatment in hospital or outpatient settings. These may be anesthesia fees, hospital fees, surgeon's fees, medications, lab test, X-rays, etc. The fee for this additional time, effort and work by your surgeon is typically equal to 30-50% of the original surgeon's fee paid and determined on a case by case basis.

Sometimes the patient's health insurance may be billed and may cover part or all of these fees. It depends upon the individual insurance policy and the procedures involved. When a patient does have health insurance, the insurance company may be billed for the surgeon's fee as well as the facility fees - depending on the procedures.

My signature below, indicates that I understand and agree to the above policy:

FOR REVIEW ONLY - PATIENT WILL SIGN DAY OF SURGERY

Patient (or legal guardian) Print | Patient (or legal guardian) Sign | Date