

**OPERATIVE AND INFORMED CONSENT FOR  
COSMETIC SURGERY**

**Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**I clearly understand and accept the following:**

(Please read and initial each paragraph when understood)

1. \_\_\_ The goal of any cosmetic procedure, is improvement, not perfection. There is no specific guarantee.
2. \_\_\_ The final result of the surgery may not be apparent for three to six months postoperatively.
3. \_\_\_ Psychological, marital, social, and/or sexual problems have been claimed to arise as a result of or from complications from this surgery. I am aware of and am willing to accept these risks as possibilities after surgery.
4. \_\_\_ I am not pregnant at this time. Injury to a pregnant woman and fetus have also been also been claimed to arise from surgery or use of any and/or all medication.
5. \_\_\_ Cosmetic surgery is a body contouring procedure and not performed for any other purpose.
6. \_\_\_ Strict adherence to the postoperative regimen discussed by Dr. Warnock and his staff (i.e. wearing of post operative garments for several days or weeks, limitation of exercise or strong exertion, avoidance of aspirin or aspirin like drugs for two weeks prior and two weeks after the surgery, use of vitamin E, etc.) is necessary in order to achieve the best possible results. I fully understand that the success or failure of the operation depends in part upon my assuming responsibility in certain aspects of my postoperative care. Should I have any questions at any time concerning this care, or concerns of my outcome or well-being, I will immediately communicate these to Dr. Warnock for clarification and/or correction.
7. \_\_\_ The surgical fee is paid for the operation itself and post operative visits. There is not guarantee that the expected or anticipated results will be achieved. I understand that should I decide to have any further surgery at my request or for any complication, that this can be done at a future time barring any medical or surgical contraindications. Additional surgical and/or office fees may be charged for the service.
8. \_\_\_ I know that the practice of medicine/surgery is not an exact science and that Dr. Warnock cannot guarantee results. I acknowledge that **NO GUARANTEE OR ASSURANCE** (expressed, written, or implied) has been made by anyone regarding the operation that I herein request and authorize. I realize that the procedure may not be completely successful and that the results may not be as I fully desire.

**Although complications following any cosmetic surgery are uncommon, I understand that the following may occur (among other complications):**

9. \_\_\_ **BLEEDING** can occur with any surgical procedure. Postoperative bleeding can cause severe swelling, bruising, and pain. This usually requires additional surgery to correct the problem. This could also involve additional incisions and additional costs. Blood transfusions for this are usually not necessary, if bleeding does occur.
10. \_\_\_ **INFECTIONS** can also occur after surgical procedures, but are uncommon after this surgery. Hospitalization, antibiotics, and additional surgery may be necessary to treat this problem. Death can result from severe infections.
11. \_\_\_ **NERVE INJURY** or **LOSS OF SENSATION** causing numbness, pain, and/or increased sensitivity of the skin may persist in the surgical area for many months. It is possible that localized areas of numbness or increased sensitivity or pain may persist permanently.
12. \_\_\_ **SKIN, MUSCLE, or BONE WEAKNESS** can occur adjacent to any operative site. Rarely do these necessitate any further surgical treatment.
13. \_\_\_ **SCARRING** is present and permanent whenever and wherever incisions are placed. Additional surgeries may be necessary if complications occur. Scars may remain reddened and/or lumpy permanently. The scars are commonly referred to as hypertrophic or keloid scars.
14. \_\_\_ **SWELLING** is present in all patients treated, and I understand that this may persist for many months. To try to minimize the problem, I agree to be patient and cooperate in every respect, especially in the postoperative care.
15. \_\_\_ **DIZZINESS** and/or **FAINTING** may occur during the first few weeks after surgery, particularly upon rising from a lying or sitting position. If this occurs, assistance and extreme caution must be exercised during any activity. Do not attempt to drive a car if these things occur.

16. \_\_\_ UNUSUAL REACTIONS TO MEDICINES OR IMPLANTS may occur and may cause rashes, itching, allergic reactions, shock, death, etc.
17. \_\_\_ PAIN occurs after any surgery. Short-term pain is experienced as a result of the operation. Long term or chronic pain sometimes occurs and is usually the result of nerve injury.
18. \_\_\_ PULMONARY EMBOLI, DEEP VEIN THROMBOSIS (blood clots to the legs that may travel to the lungs) or other vascular problems may arise as a result of this surgery. These can cause death. Hospital treatment is necessary when this occurs.
19. \_\_\_ Death is the ultimate complication of any surgical procedure and occurs only in rare instances.
20. \_\_\_ In addition to these possible complications, I am aware of general risks inherent in all surgical procedures and anesthetic administration. I accept such risks and can fault neither the doctors and/or the person giving the anesthetic if any unfortunate circumstances should arise. I understand that certain complications may result from the use of anesthetics, which may include respiratory problems (pneumonia, sore throats, bronchitis, etc.) drug reactions, paralysis, brain damage, or even death. Other risks and hazards that may result from the use of general or other types of anesthetics range from minor discomforts to injury to vocal chords, teeth or eyes, and injury to peripheral nerves may (although rarely) occur. Blood clots in the legs (phlebitis) or blood clots to the lungs (emboli) may occur with any surgery and may result in death. Auto-immune diseases (i.e., rheumatoid arthritis, scleroderma, lupus, etc.) have been implicated as a result of exposure to surgical implants, but not proven.
21. \_\_\_ I understand that smoking can significantly increase all risks of surgery, specifically wound healing and loss of tissue. It has been explained to me that if I smoke, I should have stopped two weeks before and after the surgery. I have not smoked during that time period and I understand if I have smoked, I am willing to accept the increased risks of being a smoker.
22. \_\_\_ Other complications can occur in addition to above and can be discussed if requested.
23. \_\_\_ Do you have any medical conditions now that you feel would compromise the results of your surgery, or any concerns as to why you should not have the surgery?  Yes  No Please Explain \_\_\_\_\_.

**General Information**

24. \_\_\_ I authorize Dr. Warnock and/or his staff to photograph and/or videotape myself both preoperatively and at follow-up visits as deemed necessary.
25. \_\_\_ Additional costs may be incurred by: 1. Time off work 2. Secondary surgical costs 3. Costs for hospitalization 4. Other medical costs.
26. \_\_\_ I know that the practice of medicine and surgery is not an exact science and that Dr. Warnock cannot guarantee results. I acknowledge that NO GUARANTEE (written, expressed, or implied) HAS BEEN GIVEN BY ANYONE REGARDING THE OPERATION that I herein requested and authorized. I realize that the procedure may not be successful and that the result may not be as I fully desire. Should I request additional surgery, I understand that this will result in additional charges.
27. \_\_\_ I understand the surgical fee does not include medications postoperatively, blood tests, or additional charges should complications arise.
28. \_\_\_ Should I request that the surgery be performed in the office facility, I am aware that this is not a licensed or hospital operating room with its rules, regulations, or monitoring devices, nor have any claim been made to this effect.
29. \_\_\_ I have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks or non-treatment, the procedure to be used, the risks and hazards involved, and I believe that I have sufficient information to give the informed consent and I wish to proceed with the surgery.

*I have read and I understand all of the above material with Dr. Warnock and/or his staff and I clearly understand the goals, limitations, and possible complications of t surgery and the anesthetic to be given. I agree to comply with the pre and post operative instructions, including attending the follow-up appointments, and I wish to proceed with the operation.*

\_\_\_\_\_  
PATIENT OR AUTHORIZED PERSON TO GIVE CONSENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE

\_\_\_\_\_  
STEVEN H. WARNOCK, MD

\_\_\_\_\_  
DATE