



Operative Consent for Laser Assisted Liposuction

Patient Name _____

Date _____ Time _____

I hereby authorize Laura Bennack, M.D. to perform liposuction on my (list areas)
_____.

I clearly understand and accept the following:

1. The goal of laser surgery, as in any cosmetic procedure, is improvement, not perfection.
2. The final result may not be apparent for months postoperatively, sometimes up to 12 months.
3. In order to achieve the best possible result, more than one procedure may be required. There will be a charge for any further laser treatment performed.
4. Strict adherence to the postoperative regimen (i.e. appropriate wound care) is necessary to achieve the best possible result.
5. There is no guarantee that the expected or anticipated results will be achieved.

Dr. Bennack has discussed in detail with me the information that is briefly summarized below:

A. Nature and Purpose of Liposuction

Liposuction is a body contouring technique. It is a means of reducing localized fat deposits that are difficult or impossible to remove with diet and exercise. It is not a technique for treating obesity. In liposuction a solution may be injected under the skin into the fatty tissue before it is removed. Afterward, the skin is taped or a girdle is worn for support. Patients usually return to work after a short recovery period.

B. Risks

I understand that among the known risks is bruising, lumpiness, dimpling, sagging of the skin, scarring, numbness, minor depressions, and periodic swelling of the lower legs. I am aware that, in addition to the risks specifically described above, there are other risks, such as loss of blood or infection that may accompany any surgical procedure, as well as injury to nerves which may lead to temporary numbness and/or speech difficulty. I recognize that during the course of the operation, unforeseen conditions may necessitate additional or different procedures other than those set forth above. I therefore further authorize or request that the above named surgeon, her assistants, or her designees perform such procedures which are in her professional judgment necessary and desirable.

C. Anesthesia

I understand that local and/or tumescent anesthesia is normally required when liposuction is performed. I consent to the administration of local and/or tumescent anesthesia by or under the administration of Dr. Laura Bennack. I am aware of the risks involved with the administration of anesthesia, local or tumescent, such as allergic or toxic reactions to the anesthetic and cardiac arrest.

D. Alternatives to Liposuction

Alternative methods of body contouring do exist. Although some of them have been used a longer time, they can leave long-lasting scars.

E. Informed Consent

I have had sufficient opportunity to discuss my condition and proposed surgery with Dr. Bennack and all of my questions have been answered to my satisfaction. I believe that I have adequate knowledge on which to base an informed consent to the proposed procedure.

F. Photographs

I consent to be photographed before, during and after treatment; that these photographs or videos shall be the property of the above named doctor and may be published in scientific journals and/or shown for scientific reasons with my identity protected.

G. Cooperation

I agree to keep the doctors and their staff informed of any changes in my permanent address and I agree to cooperate with them in my aftercare.

H. Financial Agreement

I understand that payment for all elective cosmetic surgery is due two weeks prior to the date of surgery. I also agree that if I do not cancel surgery at least 96 hours prior to the set date, I will accept refund of the paid fee less 50%. If surgery is not cancelled at least 48 hours prior to the set date, I will accept refund of the paid fee less 85%. I understand that in the unlikely event that a touch-up procedure is necessary in the future, only a facility fee will be charged, not a surgical fee.

Patient Signature

Date

Physician Signature

Date

Witness Signature

Date