

JOSEPH R. BURLIN, MD, INC.

PLASTIC AND RECONSTRUCTIVE SURGERY

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DIPLOMATE AMERICAN
BOARD OF PLASTIC SURGERY

FELLOW AMERICAN
COLLEGE OF SURGEONS

GENERAL CONSENT FOR TREATMENT

I hereby authorize Joseph R. Burlin, MD [and any assistants he feels necessary] to perform the following surgical procedure(s):

This operation has been thoroughly explained to me in terms that I completely understand, by both the doctor and his nursing staff, and I completely understand its nature, consequences, and most likely potential risks.

I do understand that every surgical procedure involves certain risks, limitations, and the possibility of complications. I acknowledge that these and other potential complications can occur even when the surgeon utilizes the utmost care, judgment, and skill. Dr. Burlin and his nursing staff have both explained to me, in terms that I completely understand, the most likely complications that might occur in this operation, as well as other complications which are generally quite uncommon. Dr. Burlin further acknowledges that there may be complications which are unknown to him at this time. The above risks have been explained to me to my complete satisfaction and I accept them.

There are also normal and expected conditions or consequences that can occur following any surgical procedure which are not considered complications. They are: swelling and bruising, discomfort and pain, a scar [if an incision has been made], temporary numbness and/or itching in the surgical area. [Note: this is not a complete list of all possible consequences or surgery.]

There are also common risks associated with any surgical procedure. They are: bleeding, infection, asymmetry [unevenness between the two sides], undesirable scarring, poor wound healing, sensitivity to dressings or surgical tape, problems related to anesthesia or anesthetics, and a greatly increased risk for smokers and patients who do not faithfully follow after-surgery instructions. [Note: this is not a complete list of all possible risks of surgery.]

I have an understanding of the operation which includes, but is not necessarily limited to, the above items. Alternative methods of treatment, if any, have also been explained to me, but I elect to proceed with the treatment plan as described above.

I completely understand that the practice of medicine and surgery is not an exact science, and I acknowledge that no warranties or guarantees, either expressed or implied, have been made to me as to the results of this operation or procedure. I also understand that there are absolutely no warranties or guarantees against complications or unfavorable results. I understand that the success of the procedure is, to a great extent, dependent on my closely following after-surgery instructions and post-operative care recommendations.

Even when a surgery is performed with the utmost of care and skill, instances can occur when revisionary surgery is required. In our experience this occurs very infrequently. Accordingly, I thus understand that re-

visionary surgery is sometimes necessary and, if that should be necessary for me, I understand and accept that I will be subject to additional professional fees. I further acknowledge that I will also be responsible for supplemental charges relating to (a) the use of a surgical facility [either office or hospital], (b) anesthesia services, (c) implantable materials, and (d) as well as any necessary supplies, laboratory, and pharmacy services.

I recognize that during the course of the operation that unforeseen conditions may necessitate additional or different procedures than those set forth above. I therefore further authorize and request that Dr. Burlin, his assistants or designees, perform such procedures as are, in his professional judgment, necessary and desirable, including, but not limited to laboratory services, pathology and radiology. The authority granted under this paragraph shall extend to remedying conditions that are not known to Dr. Burlin at the time the operation is commenced, including hospital admission, blood transfusions, and the need to call in other medical consultants.

I consent to the administration of local and/or general anesthetics necessary for the performance of the above surgical procedure. I understand that all forms of anesthesia involve risk and the possibility of complications, injury, and very rarely, death.

I consent to the taking of pre-operative, intra-operative, and postoperative photographs for documentation purposes. I understand that these photographs will remain the property of Dr. Burlin. These photographs will remain confidential and not used for any other purpose unless specifically authorized by me in writing.

I agree to keep Dr. Burlin's office promptly informed of any change in my address or telephone number(s), and I agree to fully cooperate with him and his staff in my care after surgery until completely discharged.

I understand that Dr. Burlin participates in a quality assurance program designed to maintain the highest standards of professional care. Quality assurance reviews are typically performed by another independent physician, physicians, or licensed agency specializing in same. I acknowledge that any of my medical records may be reviewed by outside professionals and I consent to same. I further understand that every effort will be made to insure my confidentiality.

My signature below indicates the following:

1. That I have had ample opportunity to fully discuss my condition and proposed surgery with Dr. Burlin and his staff, and that I have been verbally informed about the surgical procedure referenced above.
2. That I have had ample opportunity to ask questions, and that all of my questions have been answered to my complete satisfaction in terms that I completely understand.
3. That I have had ample opportunity to formulate an understanding of this surgery, including benefits, alternative options, risks, complications, and realistic expectations such that I am very comfortable proceeding with same.
4. That I have carefully read and understand all patient information booklets which have been provided to me concerning the procedures I am having done.
5. That I am not pregnant or nursing at this time.
6. That I am aware that smoking greatly increases the chances of complications of surgery.
7. That I am aware and acknowledge that I will be financially responsible for revisions and/or management of complications.
8. That I have fully informed Dr. Burlin and his staff of all known allergies and medications that I am currently taking [which includes prescriptions, over-the-counter medications, herbals, and any others].
9. That I have been informed as to what to expect after surgery including, but not limited to, recovery time, anticipated activity levels, time off of work, and the possibility of additional procedures.
10. That I understand that the success of this surgery is, to a large degree, dependent on my closely following instructions regarding post-operative activities and care.

11. That I authorize the disposal of any tissue or medical devices which may be removed at surgery unless I have specifically requested in writing any alternative instructions.

12. That I authorize the release of my Social Security number to appropriate agencies for legal reporting and/or medical device registration, if applicable.

13. That in the unlikely event of an exposure incident, I hereby give my permission for my blood to be drawn and tested for infectious diseases, including HIV [AIDS] and Hepatitis, at no cost to me, at the discretion of Dr. Burlin.

14. I understand that both before and after surgery photographs will be taken of me for record purposes. I understand that these photographs will remain the property of Joseph R Burlin, MD INC. These photographs will also remain confidential according to all protections of the HIPPA patient privacy regulations. No photograph will ever be shown or revealed without prior written consent.

15. That I acknowledge that the practice of plastic surgery is not an exact science, and that no guarantees, either expressed or implied, have been made to me as to the results of the surgery; nor were any guarantees made against the possibility of complications or unfavorable results.

16. I agree that if in the extraordinarily rare circumstance I should advance a dispute or legal claim against Dr. Burlin that I agree to only use an expert witness that is an active member of both the American Society of Plastic Surgeons and the American Society of Aesthetic Plastic Surgery, Inc.

17. I have been informed and understand that the medical and surgical procedures I wish to pursue require the cooperation and services of nurses, technicians, occasionally assistants and other personnel as directed by Dr. Burlin, I request and authorize such personnel to partake in my care as directed by Dr. Burlin.

18. I understand that as a result of the complexities of the human body and the healing process, unforeseen circumstances can arise at or following surgery. These circumstances can require additional medications, laboratory testing, radiology or X-ray procedures, inclusion of other physicians, return to the operating room, or even hospitalization. I further acknowledge that I will be financially responsible for these additional costs. In most cases when a secondary procedure is required, the surgeon's fee will be reduced.

- a. Most revisions are minor in nature and in most cases can be performed in our office recovery room area under local anesthesia. In such cases the minimum fee will be \$225.
- b. If, however, the revision is more involved and requires a return visit to the operating room, the patient will be responsible for the costs of the operating room, the anesthesiologist (if necessary), and any essential materials associated with the secondary procedure (i.e., implants). In such cases, the minimum fee will be \$500.

19. That I certify that I have thoroughly and completely read this treatment agreement, and that all blanks were filled in prior to my signature. The procedure, consequences, risks, and alternative treatments have been explained to me to my satisfaction. I wish to proceed with the proposed treatment.

(Patient Signature)

(Date/Time)

(Witness Signature)

(Date/Time)

I certify that I have explained the nature, purpose, benefits, risks, complications, and alternatives of the proposed procedure to the patient [or patient's legal representative]. I have answered all questions fully, and believe that the patient and/or the patient's legal representative(s) fully understand what I have explained.

(Joseph R. Burlin, MD)

(Date/Time)