

PULMONARY COMPLICATIONS- Pulmonary complications may occur secondarily to both blood clots (pulmonary emboli) or partial collapse of the lungs after general anesthesia. Should either of these complications occur, you may require hospitalization and additional treatment. Pulmonary emboli can be life-threatening or fatal in some circumstances.

SEROMA- Fluid accumulations infrequently occur in between the skin and the abdominal wall. Should this problem occur, it may require additional procedures for drainage of the fluid.

UMBILICUS- Malposition, scarring, unacceptable appearance or loss of the umbilicus (naval) may occur.

LONG TERM EFFECTS- Subsequent alterations in the body contour may occur as the result of aging, weight loss or gain, pregnancy, or other circumstances not related to abdominoplasty.

PAIN- Chronic pain may occur very infrequently from nerves becoming trapped in scar tissue after abdominoplasty.

OTHER- You may be disappointed with the results of the surgery. Infrequently, it is necessary to perform additional surgery to improve your results.

ADDITIONAL SURGERY NECESSARY- Should complications occur, additional surgery or other treatments may be necessary. Even though risks and complications occur infrequently, the risks cited are particularly associated with abdominoplasty. Other complications and risks can occur but are even more uncommon. The practice of medicine and surgery is not an exact science. Although good results are expected, there is no guarantee or warranty expressed or implied on the result that may be obtained.

HEALTH INSURANCE- Most health insurance companies exclude coverage for cosmetic surgical operations such as abdominoplasty or any complications that might occur from surgery. Please carefully review your health insurance subscriber information pamphlet.

FINANCIAL RESPONSIBILITIES- The cost of surgery involves several charges for the service provided. The total includes fees charged by your doctor, the cost of surgical supplies, anesthesia, laboratory tests, and possible outpatient hospital charges, depending on where the surgery is performed. Depending on whether the cost of surgery is covered by an insurance plan, you will be responsible for necessary co-payments, deductibles, and charges not covered. Additional costs may occur should complications develop from the surgery. Secondary surgery or hospital day-surgery charges involved with reversionary surgery would also be your responsibility.

Page 2 of 4

Patient Initials _____

Risk of Abdominal Surgery, continued

DISCLAIMER-

Informed-consent documents are used to communicate information about the proposed surgical treatment of a disease or condition along with disclosure of risks and alternative forms of treatment(s). The informed-consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances.

However, informed consent documents should not be considered all inclusive in defining other methods of care and risks encountered. Your plastic surgeon may provide you with additional or different information which is based on all the facts in your particular case and the state of medical knowledge.

Informed consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all of the facts involved in an individuals case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

IT IS IMPORTANT THAT YOU READ THE ABOVE INFORMATION CAREFULLY AND HAVE ALL OF YOUR QUESTIONS ANSWERED BEFORE SIGNING THE CONSENT ON THE NEXT PAGE.

3 of 4

Patient Initials _____

CONSENT FOR SURGERY/PROCEDURE/or TREATMENT

1. I hereby authorize **Dr. Jon Bishop** and such assistants as may be selected to perform the following procedure or treatment:
INFORMED-CONSENT ABDOMINOPLASTY SURGERY
2. I recognize that during the course of the operation and medical treatment or anesthesia, unforeseen Conditions may necessitate different procedures than those above. I therefore authorize the Above physician and assistants or designees to perform such other procedures that are in the exercise of his or 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 begins.
3. I consent to the administration of such anesthetic considered necessary or advisable. I understand That all forms of anesthesia involves risk and the possibility of complications, injury, and sometimes death.
4. I acknowledge that no guarantee has been given by anyone as to the result that may be obtained.
5. I consent to the photographing or televising of the operation(s) or procedure(s) to be performed, Including appropriate portions of my body, for medical, scientific, or educational purposes, provided my identity is not revealed by the pictures.
6. For purpose of advancing medical education, I consent to the admittance of observers to the Operating room.
7. I consent to the disposal of any tissue, medical devices or body parts which may be removed.
8. I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical-device registration, if applicable.
8. 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 THE ABOVE LISTED ITEMS (1-9). I AM SATISFIED WITH THE EXPLANATION.

PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT

WITNESS

DATE