Informed Consent For Cosmetic Procedures

Name of patient_____ Date_____

I hereby request and authorize Dr. _____, aided by any assistants he/she may require, to perform _____ on or about the _____ day of _____ for the purpose of attempting to improve _____ appearance with respect to the following conditions _____

_____

Dr. _____ has fully explained, in terms clear to me, the effects and nature of the procedure(s) to be performed, foreseeable risks involved, and alternative methods of treatment. Lastly, I have been given the opportunity to ask any questions regarding the matters covered in the preceding two sentences, and these questions have been answered to my satisfaction.

I also authorize the operating surgeon to perform any other procedures which he/she may deem necessary or desirable in attempting to improve the condition stated in paragraph one or to treat any unforeseen condition or complication that she\he may encounter during the operation.

I consent to the administration of anesthetics by or under the direction of Dr. _____ and to the use of such anesthetics and medications as he/she may deem advisable in my case.

I have been advised that the goal of the procedure I have requested is improvement in the appearance, not perfection, that there is a possibility that imperfections might ensue, and that the results might not meet my expectations or the goals that have been established. In relation to this I know that the practice of medicine and surgery is not an exact science and that, therefore, no guarantee or assurance has been made by anyone regarding the procedure which I have herein requested and authorized.

I understand that if Dr. _____ judges at any time that my procedure should be postponed or canceled for any reason, she/he may do so.

I hereby state that the information furnished to Dr. _____ during my diagnostic evaluation is correct.

I agree to follow the instructions given to me by Dr. _____ to the best of my ability before, during and after the above named procedure(s).

Signature _____ Date_____

(Patient or person authorized to give consent for the patient)

Witness _____ Date_____

Physician_____ Date_____

Financial Agreement
For Cosmetic Procedures

The patient is financially responsible for all cosmetic procedures. This office does not bill insurance companies for cosmetic procedures.

I, _____ state that I have requested a cosmetic procedure to be performed on _____ and that I understand and agree to the following:

- I am financially responsible for the full cost of the procedure.
- The Physician's office does not bill insurance companies for cosmetic procedures.
- I am to pay the full cost of the procedure seven days prior to the scheduled date. I may make payment by cash, cashier's check, personal check, MasterCard or Visa.
- I understand that if I cancel the procedure with less than three business days notice, I will receive a refund of only 50%.
- I understand that this fee includes only this procedure and the follow up care related to this procedure.

Payment Schedule:

Initials

Procedure scheduled for _____ _____

Fee paid on _____ _____

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Cancellation:

Should patient cancel the procedure less than three (3) business days prior to the scheduled time, one-half of the procedure fee will be retained by the physician.

Procedure scheduled for _____

Reason: _____

One-half procedure fee returned: _____ _____
Date

If other, amount returned: _____ _____
Date