RHINOPLASTY

Rhinoplasty is a surgical procedure designed to change the appearance and structure of the nose. Incisions are made within the nose or in an inconspicuous part of the outer nose. Some techniques use cartilage grafts or other man made materials.

I authorize and direct _____, M.D. with associates or assistants of his or her choice, to perform the procedure of rhinoplasty on _____.
(patient name)

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

Patient's Name

_____ The details of the procedure have been explained to me in terms I understand.
_____ Alternative methods and their benefits and disadvantages have been explained to me.
_____ I understand and accept possible risks and complications include but are not limited to:

- Bleeding
- Infection
- Scarring
- Damage to deeper structure
- Numbness
- Nasal septal perforation
- Asymmetry
- Chronic Pain
- Allergic reaction to topical preparations
- Nasal airway alterations
- Unsatisfactory results

_____ I understand and accept the less common complications, including the remote risk of death or serious disability that exists with any surgical procedure.
_____ I understand that tissue cannot heal without scarring and if external incisions are needed, how one scars is dependent on individual genetic characteristics. The physician will do his/her best to minimize scarring, but cannot control its ultimate appearance.
_____ I am aware that smoking during the pre- and postoperative periods can increase chances of complications.
_____ I have informed the doctor of all my known allergies.
_____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies, and any other supplements, and any other recreational drug or alcohol use.
_____ I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.
_____ I am aware and accept that no guarantees about the results of the procedure have been made.
_____ I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated level of activity and the possibility of additional procedures.
_____ I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation.
_____ Pre- and postoperative photos will be taken of the treatment for record purposes. I understand that these photos will be the property of the attending physician and will only be used as part of my medical record.
_____ The doctor has answered all of my questions regarding this procedure.

_____ Plastic surgery is not an exact science. On occasion there are instances when revisional surgery may be required to obtain maximum desired results. There may be additional minor fees associated with a touch-up/revisional surgery. This is reviewed on a case-by-case basis.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

_____ _____

Patient or Legal Representative Signature/Date Relationship

_____ _____

Print Patient or Legal Representative Name Witness Signature/Date

I certify that I have explained the nature, purpose, benefits, risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I have answered all questions fully, and I believe the ***patient/legal representative*** fully understands what I have explained.

(circle one)

_____

Physician Signature/Date

_____ copy given to patient
initial

_____ original placed in chart
initial