The Paragon Plastic Surgery & Med Spa

CONSENT FOR HAIR TRANSPLANTATION PROCEDURE

(Please underline any portion of this consent you want explained)

1. I, _____, do hereby consent and agree to having hair replacement surgery performed upon me, and any other medical services which during the procedure become medically reasonable and necessary. This includes, but is not limited to, the administration of anesthetics and/or sedatives necessary to perform a hair transplant procedure.

2. I am aware that good results will depend, in part upon my completing the necessary number of operations recommended by the doctor. However, because many variables exist, I have not been promised or guaranteed good results. I also understand that the quality and amount of preexisting hair are major factors in the ultimate result. I understand I will not have hair of the same thickness/density as I had prior to the onset of my hair loss.

3. Prior to my consenting to cosmetic surgery, I state I have read or have been given the opportunity to read and/or discussed with my physician the following literature, which has been supplied to me:
· **Brochure**
· **Preoperative and post operative Instructions**
· **A fee schedule of current charges per session**

4. I fully understand the results that I may reasonably expect. I understand hair transplants are not perfect. An explanation of this procedure has been given to me. I have had the opportunity to ask any questions regarding this procedure. I do understand that I will not obtain a full head of hair from the procedure. I understand that visibility of the sites following a transplant surgery can last for a number of days.

5. The pros, cons and alternatives to transplantation have been explained. I have the option of doing nothing, wearing a hairpiece/wig, using prescription medication or having a transplant surgery. A combination of the above is also possible. I have been informed of all options.

6. **Dr. Bishara** has suggested _1 to 2___session(s) of grafts as a minimum. I understand that more operations may be recommended later due to ongoing loss of my non-transplanted hair. I understand that all recommendations made during my consultation and treatment are estimates and may change later._____(Initial) If the doctor(s) or I feel an additional procedure is necessary, I understand there will be additional surgical fees.

7. I understand every time an incision/extraction is made in the human body, a scar will occur, although every effort will be made to make the scar inconspicuous. Scars are permanent. Superficial crusting, pinkness, or redness of the incision area may occur, but these will likely be temporary. A thickened or raised scar (a hypertrophic scar/keloid) is possible. This is more likely to occur in patients with a history of this type of scarring. Wide scarring is also possible in the donor area.

8. I have been informed that hair transplantation is generally a safe procedure, however I am aware that complications may occur. The more common complications and a partial list of rare complications of this surgery have been explained to me. A copy of that list is attached. Unforeseen, rare complications, such as unanticipated reaction to medications and anesthetics, uncommon infections, and unusual healing responses, are possible. Every unforeseen complication may not have been discussed with me in detail, but I do understand that such risks do exist.

9. I consent to and authorize the performance of hair transplant surgery by **Mark A Bishara, M.D., P.A.** and hair transplant technicians.

10. I believe I have been well informed. I understand that good results are expected, but the practices of medicine and surgery are not exact sciences. I understand knowledgeable practitioners sometimes disagree as to the best methods of treatment to achieve desired results.

PATIENT INITIALS_____

11. It has been explained to me that the amount and location of future hair loss on the scalp, including the sides and back area cannot be predicted. I do understand it is possible to lose my existing hair at any point in the future. I do understand this may affect the appearance of the grafted area. Hair transplants may not be permanent. They are usually very long lasting, but rarely have fallen out in one to ten years.

12. There is a possibility of some temporary hair loss in the back of the scalp surrounding the area where the donor strip was removed or where the extraction process takes place. In rare cases, there may be permanent loss of hair adjacent to the surgical incision/extractions. In the transplanted area shedding of existing hair, called telogen effluvium, may occur after the surgery. If this hair is at the end of its normal life span, it may not return.

13. As with all surgical procedures, results cannot be guaranteed. It is possible that some or all of the transplanted hair may fail to grow. Every effort will be made to give the maximum yield.

14. I understand the success of the hair transplant procedure is dependent upon my closely following all instructions. This includes, but is not limited to, pre-operative and post-operative activities and precautions, which have been explained to me. I have also received a written copy of these instructions.

15. This consent was read and signed while I was not under the influence of medications, which cause drowsiness.

16. I certify this form has been read or it has been read to me, the blank spaces have been filled in, and I understand its contents.

17. I have disclosed all information regarding past and present medical conditions, current medications, I do not smoke or use tobacco products as this is known to decrease success in transplant process and known drug allergies. This information is necessary so that the proper medical treatment is given at all times during the transplant procedure.

18. THIS PARAGRAPH PERTAINS TO FEMALE PATIENTS ONLY. Anesthetic agents or any other medications can be harmful to the fetus or a pregnant woman. General anesthesia should be avoided during pregnancy whenever possible. I herby state that I am not pregnant and agree to a urine pregnancy test prior to my surgical procedure. You will be given a pregnancy test at your two week preoperative appointment and another on the morning of the procedure. If you have a positive pregnancy test, your procedure will be cancelled with the option to reschedule, and you will be charged a $30 administrative fee at that time.

19. THIS PARAGRAPH PERTAINS TO SMOKERS Smokers are recognized as having a significantly higher risk of postoperative wound healing problems and complications, as well as operative and postoperative bleeding. Some complications that are at a higher risk due to smoking include: bleeding, infection, blood clots in the legs and or lungs,, poor healing, increased bruising, wound breakdown, wound and chest infections, pneumonia, thrombosis, and heart and lung complications. Patients must discontinue smoking at least 6 weeks prior to and after surgery. Although it helps to stop smoking for several weeks before and after surgery, this does not eliminate the increased risk resulting from long-term smoking. You will be given a tobacco urine test at your two week preoperative appointment, the morning of the procedure and during the postoperative period if doctor warranted. If you test positive for tobacco the procedure will be cancelled with the option to reschedule after a clean tobacco test during the preoperative period, and you will be charged a $30 administrative fee at that time.

_____(Initial) Some postoperative discomfort may be experienced.

Mark A Bishara MD PA offers procedures to obtain the best results for the patient, separate of any profit motive.

I acknowledge I am responsible for payment of these services with no fee reimbursement regardless of procedure results. I understand the fee paid is for the procedure and not for an expected result.

PATIENT INITIALS_____

The Paragon Plastic Surgery & Med Spa

Patient Name_____

Signature:_____

Date:_____**Time :**_____

Witness_____

POSSIBLE COMPLICATIONS
· Nausea and vomiting from pain medication
· Bleeding (less than 5%)
· Infection (less than 1%)
· Excessive swelling
· A temporary headache
· Temporary numbness of the scalp
· Scarring around the grafts
· Poor growth of grafts
· Reaction to medications (less than 1%)
· Fainting (less than 1%) or syncope episodes
· Occasional small-ingrown hairs - causing a cyst (less than 10%)
· Scarring of the donor area - wide scars are possible (less than 5%)
. Bruising
. Patients who smoke have a higher rate of delayed wound healing and lower graft yield. Smoking is not recommended for 2-3 weeks prior to and following the procedure.

RARE COMPLICATIONS (Partial list only)
· Keloid formation
· Complete failure of growth of transplanted hairs
· Persistent scalp pain
· Total loss of donor hair
· Permanent numbness of the scalp
· Noticeable scarring of donor area
· Loss of transplanted hair
· An allergic reaction or medication-related problem
I have read and understand all of the possible complications listed above. I accept the risks of these possible complications and consequences associated with this surgery.
Patient Signature / Date_____/_____
Witness Date_____/_____

FOR PATIENTS WHO HAVE HAD PRIOR TRANSPLANTS WITH ANOTHER PHYSICIAN:
_____(Initial) I acknowledge that prior to **contacting Dr Bishara,** I received transplants or scalp reductions from another physician. I further acknowledge **Dr Bishara**, its physicians and employees bear no responsibility for my present condition. I have been informed that my condition cannot be completely restored to its original state prior to any transplant surgery.

CONSENT FOR ANESTHESIA SERVICES
1. All forms of anesthesia involve some risk and no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare and unexpected severe complications with anesthesia can occur and include the remote possibility of infection, bleeding, drug reaction, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack, or death.
2. I understand the type of anesthesia service (listed below) will be used for my procedure and that the anesthetic technique to be used will be determined by many factors including my physical condition, the physicians' preference, as well as my own desire.
3. Nerve block anesthesia is highly effective and generally safe. In rare cases, though there have been reports of nerve damage. The instances are approximately 1:30,000. Most cases resolve on their own and do not require treatment.
4. Anesthesia to be used**: Major/Minor Nerve block without sedation**
Expected results: Temporary loss of feeling and/or movement of a specific area.

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Technique: Drug injected near nerves providing loss of sensation to the area of the operation.
Risks: Include but are not limited to, infection, convulsions, weakness, persistent numbness, residual pain, injury to blood vessels, or nerve injury.
I hereby consent to the anesthesia service described above and authorize its administration by **Mark Bishara M.D., P.A.** I also consent to an alternative type of anesthesia if necessary and deemed appropriate. I certify and acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia service and that I had ample time to ask questions and consider my decision.

_____/_____ /_____

NAME SIGNATURE DATE WITNESS INITIALS

_____/_____

PHYSICIAN SIGNATURE DATE

PATIENT INITIALS_____

PATIENT INITIALS_____