THE REED CENTRE for Ambulatory Urological Surgery

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CONSENT FOR OPERATION OR PROCEDURE
Breast Augmentation Surgery

__1. I,_____(Patient's Printed Name) hereby authorize Dr. Harold M. Reed and his assistants to perform upon me the following operation or procedure.
Standard Nomenclature: breast augmentation
Layman's Terms: breast enlargement

__2. I certify that the nature and purpose of the operation or procedure in Paragraph 1 and the risks involved, possible complications, and alternative methods of treatment have been fully explained to me by Dr. H. Reed. I completely understand the nature and consequences of the procedure. Among the possible risks and complications discussed with me by Dr. H. Reed were the following:

__a. I understand that the operation or procedure will require incisions which heal with scar tissue and that these scars are permanent. The incision lines are usually conspicuous immediately after surgery and for an indefinite period of time. I understand that healing abilities vary from person to person and that my individual response cannot be accurately predicted prior to surgery.

__b. I understand that there will be swelling and discoloration for an indeterminate period of time which will normally disappear in a few days but may require several weeks or even months to completely disappear.

__c. I understand that there will be black and blue marks on region around the breasts and chest wall, which are usually visible for several days or weeks but can last longer in some patients.

__d. I understand that, following surgery, there may be areas of numbness involving the breasts and nipples which may persist for an indefinite period of time. I also understand that sometimes fluid or blood may accumulate in the operative sites which would require aspiration or drainage.

__e. I understand that this operation carries the usual potential dangers of any operation which includes infection, bleeding, scarring, adhesions, and problems with wound healing.

__f. I understand that this operation carries the usual potential dangers of any procedure involving anesthesia.

__g. I understand that in 100% of patients who undergo breast augmentation, a fibrous capsule forms around all breast implants. In approximately 30%-50% of cases, the fibrous capsule will require future surgical procedure to either remove the capsule completely or to release the tension caused by the fibers of the capsule.

CONSENT FOR OPERATION OR PROCEDURE
Breast Augmentation Surgery

__h. I understand that leaks or ruptures may occur with saline implants. Rippling is a sensation of fluid waves under the breast, but in most cases, this does not affect the visual aesthetic result.

__i. I understand that rippling can often occur with saline implants.

__j. I understand that stretch marks may appear on the skin of my breasts following augmentation surgery.

__k. I understand that although the function of lactation (milk production) is usually preserved, it can occasionally be permanently lost.

__3. I recognize that during the course of the operation, unforeseen conditions may necessitate additional or different procedures than set forth above. I therefore authorize and consent to the performance of such additional operations or procedures that Dr. H. Reed considers therapeutically necessary or desirable on the basis of findings during the course of the operation. The authority granted herein permits Dr. H. Reed, to correct conditions that were not known or apparent prior to the beginning of the operation or procedure.

__4. I understand that other physicians might recommend a different procedure and that I am free to seek the advice of any physician or physicians I might choose. Prior to signing this document, I have taken the time to consider whether or not I wish to ask any further questions of Dr. H. Reed or whether I desire to obtain a second opinion from another physician. I understand that by signing this document, I voluntarily and of my own choice select to undergo the operation or procedure listed above.

__5. I authorize Dr. H. Reed to retain, preserve and use for scientific or therapeutic purposes or to dispose of, in accordance with the customary practice, any specimen or tissue taken from my body during this operation or procedure.

__6. I consent to be photographed and/or videotaped before, during and after the treatment and understand that these photographs and/or videos shall be the property of Dr. H. Reed and may be published in scientific journals and/or shown for scientific reasons.

__7. I am aware that the practice of medicine and surgery and in particular cosmetic surgery is not exact science. I acknowledge that, due to the nature of this operation or procedure, an exact end result cannot be predicted and that Dr. H. Reed has made no guarantees or promises of a specific result from this operation or procedure.

CONSENT FOR OPERATION OR PROCEDURE
Breast Augmentation Surgery

__8. I have received and signed for a special information sheet about surgical procedures.

__9. I understand that touch up procedures are occasionally needed in cosmetic surgery. If Dr. H. Reed determines that such procedures are needed, I will not be charged a fee for the surgeon's services although an anesthesia fee and an operating room fee may be required.

__10. I authorize Dr. H. Reed and whoever may be delegated as assistants to prescribe the use of such anesthetics as he or she may deem necessary or advisable.

__11. I acknowledge that Dr. Harold M. Reed has elected not to carry professional liability insurance, pursuant to options of Florida State Statues and 64B8-9.0091, Florida Administrative Code.

__12. I certify that I have read and fully understand the above a authorization and I intend to be legally bound hereby:

_____ _____
Patient's Signature Date of Surgery

The foregoing consent was signed in my presence:

_____
Witness of Patient's Signature

Dr. H. Reed, MD PA has defined and fully explained the operative or special procedure and the risks, possible complications and alternative methods of treatment to the above patient.