CONSENT TO MEDICAL OR SURGICAL CARE AND TREATMENT

NOTE TO PATIENT: There are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned surgery or treatment.

I authorize Dr. Donald I. Altman and such physicians, associates, assistants and other personnel or the hospital or medical facility chosen by him or her to perform the following (IN MEDICAL TERMS KNOWN AS):

Cervicofacial Rhytidectomy.

(IN COMMON TERMS KNOWN AS):

Facelift.

and/or to do any other procedures that in their judgment may be advisable to my well-being, including such procedures as are considered medically advisable to remedy conditions discovered during the above procedure.

- **GENERAL RISKS AND COMPLICATIONS.** I am satisfied with my understanding of the more common risks and complications of the treatment or procedure which are described generally on the back of this form. These risks include the risk of bleeding, infection, pain, anesthesia risks and death.

- **SPECIFIC RISKS AND COMPLICATIONS.** I am satisfied with my understanding of specific risks of this procedure or treatment including (Doctor to describe specific risks where applicable):

Bleeding, infection, asymmetry, loss of motion to any part of face scarring which may be hypertrophic or heavy, numbness.

- **ALTERNATIVE METHODS OF TREATMENT.** I am satisfied with my understanding of alternative procedures or treatments and their possible benefits and risks including (Doctor to describe specific alternative procedures and complications where applicable):

none

- **NO TREATMENT.** I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered.

- **SECOND OPINION.** I have been offered the opportunity to seek a second opinion concerning the proposed treatment or procedure.

- **ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE AND TREATMENT.** I understand that conditions may arise which are unforeseen at this time and that it may be necessary and advisable to perform operations and procedures different from, or in addition to, the procedure described. I authorize and consent to the performance of such additional or different operations and procedures as are considered necessary and advisable.

- **OTHER SERVICES.** I consent to the performance of pathology and radiology services as needed and I further authorize the disposal of any severed tissue or member in accordance with customary hospital or medical facility practice.

- **PHOTOGRAPHY.** I consent to the photographing, filming or videotaping of the treatment or procedure for educational or diagnostic use.

- **NO GUARANTEES.** I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee or give assurance of a successful result.

- **OTHER QUESTIONS.** I am satisfied with my understanding of the nature of the procedure or treatments and all of my additional questions about the treatment or procedure have been answered.

I have read and been given a copy of this form.

DATE: ______________________ TIME ______________________ AM/PM

PRINT PATIENT NAME: ______________________

SIGNATURE: ______________________

(PATIENT, PARENT OR LEGAL GUARDIAN)

TRANSLATED BY (IF APPLICABLE): ______________________

PHYSICIAN: ______________________

WITNESS: ______________________

PLEASE READ THE GENERAL INFORMATION ON BACK.

A MESSAGE TO PATIENTS ABOUT MEDICAL/SURGICAL RISKS

Medicine and surgery are generally safe, helpful and often lifesaving. However, medical or surgical procedures of any type involve the taking of risks, ranging from minor to serious (including the risk of death). It is important to be aware of the following possible risks before receiving the treatment you and your physician are planning. The following may be the reactions of your body to medical/surgical operations or procedures:

1. **INFECTION:** Invasion of tissue by bacteria or other germs occurs to some degree whenever a cut, incision or puncture is made. In most instances, through the natural defense mechanisms of the body, healing of the affected area occurs without difficulty. In some instances antibiotic medicines are prescribed and at times additional surgical measures may be necessary to combat infection.

2. **HEMORRHAGE:** The cutting of blood vessels causes bleeding and this occurs in every surgical incision. This bleeding is usually controlled without difficulty. At times, blood transfusions are required to replace blood loss. If blood transfusions are given, there are additional risks of liver inflammation, hepatitis, and the possibility of receiving Acquired Immune Deficiency Syndrome (AIDS). There is no absolutely reliable way to predict these unwanted reactions, some of which may be quite serious and even lead to death.

3. **DRUG REACTIONS:** Unexpected allergies, lack of proper response to medications or illness caused by the prescribed drugs are possibilities. It is important for you to inform your physician and your anesthesiologist or certified registered nurse anesthetist of any problem you or your family have had with reactions to drugs and which medications you have taken in the past six months, including over-the-counter drugs, especially aspirin.

4. **ANESTHESIA REACTIONS:** There may be unusual or unexpected responses to the gases, drugs or methods used to anesthetize you which can lead to difficulties with lung, heart or nerve function. Eating or drinking before anesthesia increases the risks of vomiting which may cause significant complications. Inform your anesthesiologist or certified registered nurse anesthetist of problems you and your family have had with anesthesia.

5. **BLOOD VESSEL INFLAMMATION AND CLOTTING:** It is impossible to predict the occurrence of blood vessel inflammation and clotting problems. If blood clots form, they can move from where they formed to other areas of the body and cause injury.

6. **INJURY TO OTHER ORGANS:** Because of the closeness of other organs to the area being operated on, there may be injury to other organs. The stress of surgery or the procedure may also harm other organ systems of the body.

7. **OTHER RISKS:** It is not possible to list all the possible risks and complications, and their variations, that may arise in any surgical operation or medical procedure. Each situation depends upon the purpose and nature of the operation or procedures. Your physician is willing to discuss further with you various details about other risks.

ALTERNATIVES TO TREATMENT

Although you and your doctor have decided upon this procedure, do not hesitate to discuss the reasons for the choice and the alternatives available for treatment of your condition. In addition, be sure to ask your doctor any other questions that you may have about your treatment.

PATIENT SIGNATURE

PLEASE DATE

IRVINE PLASTIC SURGERY CENTER
PATIENT PRE-ANESTHESIA QUESTIONAIRE

NAME:______________________________ AGE:________ CURRENT WEIGHT:________HEIGHT:__________

PHONE NUMBER YOU CAN BE REACHED AT THE
NIGHT BEFORE YOUR SURGERY:(____)____________________

PHONE NUMBER YOU CAN BE REACHED NIGHT AFTER SURGERY(____)________________________
RELATIONSHIP & NAME OF PERSON ACCOMPANYING YOU:___________________________________

YES NO

_____ _____ 1. Have you ever had any type of anesthesia in the past? Please list Surgeries.______________________
____

_____ _____ 2. Have you or any family members had a problem with anesthesia? Malignant Hyperthermia?________
If so which ones?____

_____ _____ 3. Are you allergic to any medications? Latex allergy? Food allergy?
If so which ones and reaction ?____

_____ _____ 4. Do you use ANY medications, drugs, or eye drops? Diet pills or supplements?
If so please list? ____

_____ _____ 5.Have you had Hepatitis B vaccination? ____

_____ _____ 6. Have you taken any steroid medication in the past six months?

_____ _____ 7. **Female patients**: possibility of pregnancy at time of surgery? (Yes or No) date of last period: ________

<u>HAVE YOU EVER HAD ANY OF THE FOLLOWING?</u>

_____ _____ 8. High blood pressure?
_____ _____ 9. Chest pain (angina), heart palpitations(arrhythmia)?
_____ _____ 10. Heart attack, heart failure, or heart murmur?
_____ _____ 11. Diabetes?
_____ _____ 12. Thyroid disease or goiter?
_____ _____ 13. Asthma, TB, sleep apnea or other lung problems?
_____ _____ 14. Poor circulation, history of blood clots to lungs or legs?
_____ _____ 15. Seizures, convulsions, black outs, fainting spells, or stroke?
_____ _____ 16. Jaundice, hepatitis, or liver problems?
_____ _____ 17. Hiatal hernia, ulcers, GERD, gastric reflux, gallstones or history of Hepatitis?
_____ _____ 18. Bleeding or clotting problems, anemia?
_____ _____ 19. Kidney problems, recent urinary tract infections or kidney stones?
_____ _____ 20. Recent fever, cold, cough, or sore throat?
_____ _____ 21. Do you smoke? How much?__________________________________
_____ _____ 22. Do you drink alcohol? How much?____________________________
_____ _____ 23. Do you have any loose teeth, dentures, bridges, capped teeth, or crowns?
_____ _____ 24. Chronic pain, artificial joints?

Signature:____ Date: _______________________________

Signature of parent or guardian, if patient is a minor____

Irvine Plastic Surgery Center
16300 Sand Canyon Ave. Suite 1011
Irvine, CA 92618
(949) 727-3999

Surgery Questionnaire

1. Have you experienced motion sickness in the past?

   Yes____ No____

2. Have you experienced nausea after previous surgeries?

   Yes____ No____

3. Have you taken any medication in the past that has caused nausea?

   Yes____ No____

   If yes, please list medication if known.

   ____

4. Do you anticipate that you will be on your menstrual cycle at the time of your procedure?

   Yes____ No_____

Patient Signature:______________________Date:____________

POST OPERATIVE ANESTHESIA INSTRUCTIONS

1. You must have an adult drive you home from the facility. You will not be allowed to drive yourself.
2. Arrangements must have been made for supportive post-operative care by an adult for a minimum of 24 hours post operatively.
3. The effects of anesthesia can persist for 24 hours. You must exercise extreme caution before engaging in any activity that could be harmful to yourself or others.
4. Please avoid the use of alcoholic beverages for the first 24 hours and/or while pain medication is being used.
5. You must follow your Surgeons instructions as indicated for specific surgery instructions. Notify your Surgeon if any unusual changes in your condition.
6. Take only medication that is prescribed by your post operative surgical instruction list

- I certify that I have read and had explained to me and fully understand the above instructions.

PATIENTS SIGNATURE:______________________________

RESPONSIBLE PARTY:______________________________

TIME:____________________ DATE:____________________

WITNESS:______________________________

CONSENT FOR OUT PATIENT ANESTHESIA

Permission is hereby granted for monitored intravenous/general anesthesia for outpatient surgery. I have read, understood, and will comply with the written "Instructions To Patients For Outpatient Anesthesia."

The common problems that sometimes occur in anesthesia have been explained to me and I understand them. I am advised that though problems are not expected, complications cannot be anticipated and that there can be no guarantee, expressed or implied, that there will be no complications.

I will not drive home or use public conveyance. Someone will take me home. I realize that impairment of full mental alertness may persist for several hours in the post-anesthesia period and I will avoid any decision or activity post-operatively which depends upon full concentration or mental judgement to insure safe completion of that activity. I will not drive a car, operate machinery, or ingest alcohol for twenty-four hours after leaving the surgery center.

PATIENTS SIGNATURE:______________________________

TIME:____________________ DATE:____________________

WITNESS:______________________________

Donald I Altman, M.D.
16300 Sand Canyon Avenue, Suite 1011
Irvine, Ca. 92618
949.727.3999

Office Policy Regarding Revision on Cosmetic Surgery

The relationship between Dr. Altman and his patients is such that every attempt will be made to perform surgery to the best of his ability. Under some circumstances, a result may occur which is less than desirable on the part of the surgeon, as well as the patient. Under these circumstances, a revision may be required. Each patient and each problem will be reviewed on an individual basis. In most cases, the surgeon's fee will be eliminated or greatly reduced, and the patient will be responsible for a fee for anesthesia and operating room, if the original procedure required these services. Please do not hesitate to discuss this with Dr. Altman or his staff if you have any questions.

Date:______________________________ Time:______________________________

Patient Signature:____

IRVINE PLASTIC SURGERY CENTER
COSMETIC AND PLASTIC SURGERY
16300 SAND CANYON AVE, SUITE 1011
IRVINE, CA. 92618
(949) 727-3999

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I authorize Dr. Altman to disclose complete information concerning medical findings and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Doctor Altman's sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

Patient Signature_____________________________ Date_______________

Witness____________________________________Date_______________

Irvine Plastic Surgery Center
Cosmetic and Plastic Surgery
16300 Sand Canyon Avenue, Suite 1011
Irvine, Ca. 92618
(949)727-3999

Consent Form For The H.I.V. Antibody Blood Test

I have been informed that my blood will be tested in order to detect whether or not I have antibodies in my blood to the Human Immunodeficiency Virus (H.I.V), which is the probable causative agent of Acquired Immune Deficiency Syndrome (A.I.D.S.). I understand that the test is performed by withdrawing blood and using a substance to test blood.

I have been informed that the test is new and its accuracy and reliability is still uncertain and that the test results in some cases may indicate that a person has antibodies to the virus when the person does not (false positive) or fail to detect that a person has antibodies (false negative). I also have been informed that a positive blood test does not mean that I have A.I.D.S. and that in order to diagnose A.I.D.S. other means must be used in conjunction with the blood test.

I have been informed that if I have any questions regarding the nature of the blood test, its expected benefits, its risks, and alternative tests, I may ask the questions before I decide to consent to the blood test.

I understand that the results of this blood test will only be released to my providence of health care. I further understand that no other release of the results will be made without my written authorization.

By my signature below, I acknowledge that I have been given all of the information I desire concerning the blood test and release of results and have had all my questions answered. Further, I acknowledge that I have given consent for the performance of a blood test to detect antibodies to the human immunodeficiency virus (H.I.V).

Printed Name:____

Signature:___________________________________ Date:__________

Witness:_____________________________________ Date:__________

Irvine Plastic Surgery Center
(949) 727-3999

<u>Recommended foods and fluids for the day and evening after surgery:</u>

Chicken Soup

Saltine Crackers

Apple Sauce

Coca-Cola

Jell-O

Toast

No Dairy, Citrus juices or spicy foods for the first 24 hours.

Some individuals will have problems with nausea after surgery. We highly recommend having "Gaviscon" antacids on hand.

Additionally, some individuals will become constipated after the prolonged use of pain medications that include narcotics such as Percocet and or Darvocet, for this problem we recommend the use of "Colace" stool softener.

Patient
Signature:________________________________Date:_______________

Irvine Plastic Surgery Center

Medications Which Increase Bleeding. Avoid Three weeks prior to surgery.

This is not a complete list. Please check with your pharmacist if you have any questions.

**** If you must take medication for pain relief, please take Tylenol (as directed) ****

PLEASE CHECK ALL MEDICATIONS YOU ARE TAKING FOR ASPIRIN CONTENT. IF YOU ARE TAKING A MEDICATION NOT LISTED BELOW, PLEASE CONTACT YOUR PHARMACIST OR CALL THE OFFICE. (949)727-3999

Advil
Aggrenox
Aleve
Alka Seltzer
Alka Seltzer Plus Antacid
Alka Seltzer Cold Medicine
Alka Seltzer Pain Reliever
Antacids
Anaprox
Arthrotec
A.P.C. Tablets
A.P.C. Tablets w/Butalbital
A.P.C. Tablets w/Codiene
Arthritis Pain Formula
Athritis Strength Bufferin
Ascriptin
Ascriptin A/D
Ascriptin w/ Codiene
Aspergum
Aspirin Suppositories/Uniserts
Aspirin Tablets
Aspirin w/ Codiene
Bayer Aspirin
Bufferin & Tri-Buffered Bufferin
Buffered Aspirin
Buffez
Butalbital Compound
Clinoril
Coricidin "D"
Coricidin Tablets
Coumadin
Darvon Compound 65
Darvon w/ASA
Daypro
Decongestant Tablets
Diet Medications
Dolobid
Dristan Decongestant Tabs & Capsules
Empirin
Equagesic
Excedrin
Extra Strength Bufferin
Feldene
Fiornal
Fiornal w/Codiene
Goody's Headaches Powder
Goddy's Extra Strength Tablets
Halfprin
Heparin
Ibuprofen
Idenal
Indocin
Isoallele w/Coricidin
Lodine
Lovenox
Micainin
Midol
Mobic
Momentum Muscular Backache Formula
Motrin
Norgesic
Norgesic Forte
Norwich Aspirin & Extra Strength
Nuprin
Pamprin
Pepto-Bismo
Percodan Demi Tablets
Persantine-Dipyridamole
Persistin
Phen-fen
Phentermine(Diet Pills)
Plaquenil-Hydroxychloroquine
Plavix
Ponstel
Propoxyphene Compound 65
Pulvules
Quiet World Analgesic
Relafen
Sine Off
Soma Compound
St. Josephs's Cold Tablets
St. Joseph's for Children
Talwin Compound
Therapy Bayer
Toradol
Trigesic
Triaminic
Vanquish Caplets
Vitamin E

**** Avoid Herbals and Herbal tea's i.e. Chamomile. In addition avoid: Feverfew, Garlic, Ginger, Ginkgo Biloba, Ginseng, Siberian, St. John's Wort, Evening Primrose oil, Kava Kava, Licorice, MaHong, Valerian ****

******Do Not Drink Smoothies, Naked Juices, Jamba Juices, Etc...******

PATIENT
SIGNATURE____________________________________DATE__________

Revised 6/4/2013

Irvine Plastic Surgery Center
16300 Sand Canyon Ave, Suite 1011
Irvine, Ca. 92618
Phone: (949) 727-3999
Fax: (949) 727-9053

How To Take Your Medication

After Surgery: Very Important. Eat prior to taking your pain medication.

Pain Medication:

Percocet (Oxycodone) : Take ½ tablet by mouth every 2-3 hours for the first couple of days after surgery. Take with food-caution drowsiness.

Anti-Nausea/ vomiting

Zofran place one tablet under tongue till dissolved every 8 hrs or as needed for nausea/vomiting

Irvine Plastic Surgery Center
16300 Sand Canyon Avenue, Suite #1011
Irvine, California 92618
949 727 3999

Patient Name:
Date:

FACELIFT

- Sleep with your head up on a couple of pillow or elevated if possible. It would be helpful to have assistance the first few times that you stand up or ambulate to the bathroom.
- Diet: Advance your diet slowly. Start out with foods that are easy to digest such as crackers, chicken soup, Jello, etc. Take food prior to taking any pain medications.
- Keep dressings in place until the first day after surgery. The dressings will be removed and replaced for an additional 24 hours in the office.
- Pain Medications: Take as directed
- Nausea: Notify the doctor

Swelling is usually at its maximum level after 48 to 72 hours. Please let the office know if there is severe pain that is not relieved by medications.

Normally, patients can shower one or two days after surgery. Your doctor will give you instructions.

Sutures and / or staples are usually removed between 5 and 7 days after surgery. The office will schedule follow up appointments.

Please call the office immediately for:
- Sudden increase in pain, swelling, or tenderness
- Fever/ Flu like symptoms
- Nausea or vomiting

Post operative visit (s):
____

Dr. Altman

Irvine Plastic Surgery Center
16300 Sand Canyon Ave, Suite 1011
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Phone: (949) 727-3999
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Irvine Plastic Surgery Center
16300 Sand Canyon Avenue, Suite #1011
Irvine, California 92618
949 727 3999

Patient Name:
Date:

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- Nausea or vomiting

Post operative visit (s):

____

Dr. Altman

INFORMED-CONSENT-FACELIFT SURGERY (Rhytidectomy)

INSTRUCTIONS

This is an informed-consent document that has been prepared to help your plastic surgeon inform you concerning face lift surgery, its risks, and alternative treatment.

It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent for surgery as proposed by your plastic surgeon.

INTRODUCTION

Facelift, or rhytidectomy, is a surgical procedure to improve visible signs of aging on the face and neck. As individuals age, the skin and muscles of the face region begin to lose tone. The facelift cannot stop the process of aging. It can improve the most visible signs of aging by tightening deeper structures, re-draping the skin of face and neck, and removing selected areas of fat. A facelift can be performed alone, or in conjunction with other procedures, such as a browlift, liposuction, eyelid surgery, or nasal surgery.

Facelift surgery is individualized for each patient. The best candidates for facelift surgery have a face and neck line has begun to sag, but whose skin has elasticity and whose bony structure is well defined.

ALTERNATIVE TREATMENT

Alternative forms of management consist of not treating the laxness in the face and neck region with a facelift (rhytidectomy). Improvement of skin laxity, skin wrinkles and fatty deposits may be attempted by other treatments or surgery such as chemical face peels or liposuction. Risks and potential complications are associated with alternative forms of treatment.

RISKS of FACELIFT (Rhytidectomy) SURGERY

Every surgical procedure involves a certain amount of risk and it is important that you understand the risks involved with facelift (rhytidectomy). An individual's choice to undergo a surgical procedure is based on the comparison of the risk to potential benefit. Although the majority of patients do not experience the following complications, you should discuss each of them with your plastic surgeon to make sure you understand the risks, potential complications, and consequences of facelift (rhytidectomy).

Bleeding- It is possible, though unusual, that you may have problems with bleeding during or after surgery. Should post-operative bleeding occur, it may require emergency treatment to drain accumulated blood or require a blood transfusion. Do not take any aspirin or anti-inflammatory medications for ten days before surgery, as this contributes to a greater risk of bleeding. Hypertension (high blood pressure) that is not under good medical control may cause bleeding during or after surgery. Accumulations of blood under the skin may delay healing and cause scarring.

Infection- Infection is unusual after this surgery. Should an infection occur, additional treatment including antibiotics or surgery may be necessary.

Scarring- Although good wound healing after a surgical procedure is expected, abnormal scars may occur within the skin and deeper tissues. Scars may be unattractive and of different color than the surrounding skin. There is the possibility of visible marks from sutures. Additional treatments may be needed to treat scarring.

Damage to deeper structures- Deeper structures such as blood vessels, muscles, and particularly nerves may be damaged during the course of surgery. The potential for this to occur varies with the type of facelift procedure performed. Injury to deeper structures may be temporary or permanent.

Asymmetry- The human face is normally asymmetrical. There can be a variation from one side to the other in the results obtained from a facelift procedure.

Surgical anesthesia- Both local and general anesthesia involve risk. There is the possibility of complications, injury, and even death from all forms of surgical anesthesia or sedation.

Nerve injury- Motor and sensory nerves may be injured during a facelift operation. Weakness or loss of facial movements may occur after facelift surgery. Nerve injuries may cause temporary or permanent loss of facial movements and feeling. Such injuries may improve over time. Injury to sensory nerves of the face, neck and ear regions may cause temporary or more rarely permanent numbness. Painful nerve scarring is very rare.

Chronic pain- Chronic pain is a very rare complication after a facelift.

Skin disorders/skin cancer- A facelift is a surgical procedure for the tightening of skin and deeper structures of the face. Skin disorders and skin cancer may occur independently of a facelift.

Unsatisfactory result- There is the possibility of a poor result from the facelift surgery. This would include risks such as unacceptable visible deformities, loss of facial movement, wound disruption, and loss of sensation. You may be disappointed with the results of surgery. Infrequently, it is necessary to perform additional surgery to improve your results.

Allergic reactions- In rare cases, local allergies to tape, suture material, or topical preparations have been reported. Systemic reactions which are more serious may occur to drugs used during surgery and prescription medicines. Allergic reactions may require additional treatment.

Hair loss- Hair loss may occur in areas of the face where the skin was elevated during surgery. The occurrence of this is not predictable.

Delayed healing - Wound disruption or delayed wound healing is possible. Some areas of the face may not heal normally or may take a long time to heal. Areas of skin may die. Frequent dressing changes or further surgery may be required to remove the non-healed tissue.

Smokers have a greater risk of skin loss and wound healing complications.

Long term effects- Subsequent alterations in facial appearance may occur as the result of aging, weight loss or gain, sun exposure, or other circumstances not related to facelift surgery. Facelift surgery does not arrest the aging process or produce permanent tightening of the face and neck. Future surgery or other treatments may be necessary to maintain the results of a facelift operation.

HEALTH INSURANCE

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

ADDITIONAL SURGERY NECESSARY

There are many variable conditions in addition to risk and potential surgical complications that may influence the long term result from facelift surgery. Even though risks and complications occur infrequently, the risks cited are the ones that are particularly associated with facelift surgery. Other complications and risks can occur but are even more uncommon. Should complications occur, additional surgery or other treatments may be necessary. 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 results that may be obtained.

FINANCIAL RESPONSIBILITIES

The cost of surgery involves several charges for the services 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 revisionary surgery would also be your responsibility.

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 individual 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.

CONSENT FOR SURGERY/ PROCEDURE or TREATMENT

1. I hereby authorize Dr. ______________________________ and such assistants as may be selected to perform the following procedure or treatment:

   ____

   I have received the following information sheet:

   INFORMED-CONSENT for FACELIFT (RHYTIDECTOMY) 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 is begun.

3. I consent to the administration of such anesthetics 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 results 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 purposes 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.

9. 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

Date______________________ ______________________________Witness

Irvine Plastic Surgery Center
16300 Sand Canyon Ave., Suite 1011
Irvine, CA. 92618
949.727.3999

Advance Health Care Directive

An advance health care directive is a written expression of what a person does and doesn't want if he or she becomes ill and can't communicate or make decisions. The directive contains written instructions concerning future medical care and / or names your healthcare decision maker to act for you. Whereas death is a very uncomfortable subject, and as of this date, there has never been a death in the Irvine Plastic Surgery Center, it is a subject that by law must be addressed.

As a patient you have the right to review this form and sign it. The form is enclosed. (see following pages)

You also have the right to not sign this form, but recognize that it was presented to you. Your signature below confirms that you are not interested in learning more or signing the Advance Health Care Directive form.

Patient
Signature:____________________ Date:________________

Witness:______________________

Advance Health Care Directive Form Instructions

You have the right to give instructions about your own health care.

You also have the right to name someone else to make health care decisions for you.

The Advance Health Care Directive form lets you do one or both of these things. It also lets you write down your wishes about donation of organs and the selection of your primary physician. If you use the form, you may complete or change any part of it or all of it. You are free to use a different form.

INSTRUCTIONS

Part 1: Power of Attorney

Part 1 lets you:

- **name** another person as **agent** to make health care decisions for you if you are unable to make your own decisions. You can also have your agent make decisions for you right away, even if you are still able to make your own decisions.
- **also name** an **alternate agent** to act for you if your first choice is not willing, able or reasonably available to make decisions for you.

Your **agent** may not be:

- an operator or employee of a community care facility or a residential care facility where you are receiving care.
- your supervising health care provider (the doctor managing your care)
- an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Your **agent** may make all health care decisions for you, unless you limit the authority of your agent. You do not need to limit the authority of your agent.

If you want to limit the authority of your agent the form includes a place where you can limit the authority of your agent.

If you choose not to limit the authority of your agent, your agent will have the right to:

- Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
- Choose or discharge health care providers (i.e. choose a doctor for you) and institutions.
- Agree or disagree to diagnostic tests, surgical procedures, and medication plans.
- Agree or disagree with providing, withholding, or withdrawal of artificial feeding and fluids and all other forms of health care, including cardiopulmonary resuscitation (CPR).
- After your death make anatomical gifts (donate organs/tissues), authorize an autopsy, and make decisions about what will be done with your body.

Part 2: Instructions for Health Care

You can give specific instructions about any aspect of your health care, whether or not you appoint an agent.

There are choices provided on the form to help you write down your wishes regarding providing, withholding or withdrawal of treatment to keep you alive.

You can also add to the choices you have made or write out any additional wishes.

You do not need to fill out part 2 of this form if you want to allow your agent to make any decisions about your health care that he/she believes best for you without adding your specific instructions.

Part 3: Donation of Organs

You can write down your wishes about donating your bodily organs and tissues following your death.

Part 4: Primary Physician

You can select a physician to have primary or main responsibility for your health care.

Part 5: Signature and Witnesses

After completing the form, **sign and date it** in the section provided.

The form must be signed **by two qualified witnesses** (see the statements of the witnesses included in the form) **or** acknowledged before a notary public. **A notary is not required if the form is signed by two witnesses. The wittnesses must sign the form on the same date it is signed by the person making the Advance Directive.**

See part 6 of the form if you are a patient in a skilled nursing facility.

Part 6: Special Witness Requirement

A Patient Advocate or Ombudsman must witness the form ***if you are a patient in a skilled nursing facility*** (a health care facility that provides skilled nursing care and supportive care to patients). See Part 6 of the form.

You have the right to change or revoke your Advance Health Care Directive at any time

If you have questions about completing the Advance Directive in the hospital, please ask to speak to a Chaplain or Social Worker.

We ask that you
complete this form in English
so your caregivers can understand your directions.

Advance Health Care Directive

Name______________________________

Date______________________________

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form also lets you write down your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or change all or any part of it. You are free to use a different form.

You have the right to change or revoke this advance health care directive at any time.

Part 1 — Power of Attorney for Health Care

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent:______________________________

Relationship______________________________

Address: ______________________________

____

Telephone numbers: (Indicate home, work, cell) ______________________________

ALTERNATE AGENT (Optional): If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Name of individual you choose as alternate agent:______________________________

Relationship______________________________

Address: ______________________________

____

Telephone numbers: (Indicate home, work, cell) ______________________________

SECOND ALTERNATE AGENT (optional): If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Name of individual you choose as second alternate agent: ______________________________

Address: ______________________________

____

Telephone numbers: (Indicate home, work, cell) ______________________________

.2) AGENT'S AUTHORITY: My agent is authorized to 1) make all health care decisions for me, including ecisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health are to keep me alive, 2) to choose a particular physician or health care facility, and 3) to receive or onsent to the release of medical information and records, except as I state here:

____

____

Add additional sheets if needed.)

1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective hen my primary physician determines that I am unable to make my own health care decisions unless I itial the following line.

I initial this line, my agent's authority to make health care decisions for me takes effect immediately. ____

1.4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this ower of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the xtent known to my agent. To the extent my wishes are unknown, my agent shall make health care lecisions for me in accordance with what my agent determines to be my best interest. In determining my est interest, my agent shall consider my personal values to the extent known to my agent.

1.5) AGENT'S POST DEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

____

____

Add additional sheets if needed.)

1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named. _______ (initial here)

Part 2 — Instructions for Health Care

If you fill out this part of the form, you may strike out any wording you do not want.

(2.1) **END-OF-LIFE DECISIONS**: I direct my health care providers and others involved in my care to provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

☐ a) Choice Not To Prolong
I do not want my life to be prolonged if the likely risks and burdens of treatment would outweigh the expected benefits, or if I become unconscious and, to a realistic degree of medical certainty, I will not regain consciousness, or if I have an incurable and irreversible condition that will result in my death in a relatively short time.

Or

☐ b) Choice To Prolong
I want my life to be prolonged as long as possible within the limits of generally accepted medical treatment standards.

(2.2) OTHER WISHES: If you have different or more specific instructions other than those marked above, such as: what you consider a reasonable quality of life, treatments you would consider burdensome or unacceptable, write them here.

____

____

____

____

____

Add additional sheets if needed.)

Part 3 — Donation of Organs at Death (Optional)

(3.1) Upon my death (mark applicable box):

☐ I give any needed organs, tissues, or parts

☐ I give the following organs, tissues or parts only:______________________________

☐ I do not wish to donate organs, tissues or parts.

My gift is for the following purposes (strike out any of the following you do not want):

Transplant   Therapy   Research   Education

Part 4 — Primary Physician (Optional)

(4.1) I designate the following physician as my primary physician:

Name of Physician:____

Address: ____

____

Telephone: ____

Part 5 — Signature

(5.1) EFFECT OF A COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign name: ______________________________ Date: ______________

(5.3) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly nor an employee of an operator of a residential care facility for the elderly.

FIRST WITNESS

Print Name: ____

Address: ____

Signature of Witness: ______________________________ Date: ______________

SECOND WITNESS

Print Name: ____

Address: ____

Signature of Witness: ______________________________ Date: ______________

(5.4) ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate on his or her death under a will now existing or by operation of law.

Signature of Witness: ____

Signature of Witness: ____

Part 6 — Special Witness Requirement if in a Skilled Nursing Facility

(6.1) The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OF OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by section 4675 of the Probate Code:

Print Name:______________________________ Signature: ______________________

Address: ____ Date: ______________

Certificate of Acknowledgement of Notary Public (Not required if signed by two witnesses)

State of California, County of ______________________________ On this ________ day of ______________________ , ____________ , before me, the undersigned, a Notary Public in and for said State, personally appeared ______________________________ , personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument, and acknowledged
to me that he/she executed it.

Seal

WITNESS my hand an official seal.

Signature______________________________