AEGEAN

MEDICAL

Liposuction/Lipotransfer/Skin Tightening Procedure Consent Form

Name: _____ DOB: _____ Date: _____

I have had the opportunity to ask questions about the procedure(s), the limitations and possible complications. I express that I clearly understand and accept the following:

--The goal of liposuction/liposculpture, lipotransfer and/or skin tightening procedures, as in any other cosmetic procedure, is improvement of appearance; not perfection. It does not guarantee the reduction/tightening of any measurements, including the neck, waist, and all other areas.
--The final results may not be apparent for 3-6 months post-procedure. There is no guarantee that the expected or anticipated results will be achieved. Remember that the goal is significant improvement, not perfection.
_____(initial) In order to achieve the best possible results, a "touch-up" procedure may be required. There will be a supply cost charged to you for this service.
--Areas of "cottage cheese" texture (cellulite) may show some improvement, but will likely have little change after liposuction/liposculpture and/or skin tighenting procedure.
--Liposuction/liposculpture and/or lipotransfer procedure is a body contouring procedure and is not performed for purposes of weight reduction.
--Strict adherence to the post-procedure regiment; such as wearing a compression garment or other supportive garment, exercise, diet and all other regimes discussed, is necessary in order to achieve the best possible results.
--Bruising is a common result of the procedure(s). Any bruising that occurs should resolve within 2 to 3 weeks.
--Burns of the skin or subcutaneous tissue is possible with skin tightening. Any burns should heal within 1-2 months. There is a possibility this can leave a scar.
--Post-procedure pain can be controlled in the majority of patients with Tylenol or Ibuprofen. However some patients require more aggressive pain management. For this reason you may receive a prescription for a narcotic pain reliever to take as necessary.
--Bleeding is rare, and in rare instances could require hospitalization and blood transfusion. It is possible that blood clots may form under the skin and require subsequent surgical drainage. A collection of lymph fluid (Seromas) may develop which will require drainage.
--Skin irregularities, lumpiness, hardness and dimpling may appear post-procedure. Most of these problems disappear with time, but localized skin firmness, lumpiness and or irregularities can be permanent.
--In dark-skinned patients, hyper-pigmented scars (dark to black scars) can occur and be permanent. Other objectionable scarring such as keloids is possible, but rare due to the small size of the incisions. Other complications such as hematomas (collection of blood under the skin) or skin discoloration can occur. If loose skin is present in the treated areas, it may or may not shrink to conform to the new contour.
--Infection is rare, but should it occur, treatment with antibiotics and/or surgical drainage may be required.
--Numbness or increased sensitivity of the skin over the treated areas may persist for months. It is possible that localized areas of numbness or increased sensitivity could be permanent.
--Nerve Injury is possible: Body/Face→weakness of affected area; Face→temporary change in facial expression/smile. These could be permanent.

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--Skin necrosis (dead skin) may occur as a result and may require skin grafting which will leave significant scarring. This is a very rare complication.
--Dizziness may occur during the first weeks following procedure, particularly upon arising from a lying or sitting position. If this occurs, extreme caution must be exercised while walking. Do not attempt to drive a car if dizziness is present.
--Allergic or toxic responses to anesthetic solution are extremely rare, but possible.
--In addition to these possible complications, I am aware of the general risks inherent in all surgical procedures and anesthetic administration.
_____(initial) I have been informed of the pre and post-procedure instructions and given a copy.

FOR FEMALE PATIENTS
--I have informed my doctor about my use of birth control pills. I have been advised that antibiotics and other medications may reduce the preventive effect of birth control pills and may result in conception and pregnancy. I agree to consult with my physician to initiate alternative forms of birth control during the period of my treatment, and to continue those methods until advised by my physician that I can return solely to the use of birth control pills.
--I understand that I may not be a candidate for this procedure if I am pregnant, might be pregnant, or am nursing a child. I agree to notify Dr. Tellis if I am or become pregnant.

- My signature certifies that I have discussed the above materials with Angelo A. Tellis M.D. and/or Aegean Medical staff, and I understand the goals, limitations, and possible complications of liposuction and/or lipotransfer, and I wish to proceed with the procedure.
- I hereby authorize and give my consent to Angelo A. Tellis M.D., to perform upon me:
  - ☐ **Liposuction** ☐ **Lipotransfer** ☐ **Skin Tightening with**_____ and whatever procedures, treatments or technical procedures which may be deemed necessary or advisable in the treatment of my case. I also give my permission to have such anesthetics administered as are deemed necessary or advisable.
- I give permission to Aegean Medical staff to take before and after photographs. These photos will only be used for myself and Aegean Medical staff to show the changes from my procedure.
- This particular procedure(s) which I am about to undergo has been explained me in detail and I understand in general what is to be done, that there are calculated risks, and that Angelo A. Tellis M.D. and Aegean Medical staff have not made any guarantee whatsoever.

_____ _____ _____
Patient Signature DOB Date

_____ _____
Witness Signature Date

AMERICAN ACADEMY OF COSMETIC SURGERY
Educating for Patient Safety

_____
Angelo A. Tellis MD

AEGEAN
MEDICAL

PHOTO/VIDEO RELEASE CONSENT

I, _____ , give permission to Aegean Medical staff to take and use photographs, audio, and video recordings of me without compensation, including appropriate portions of my body, for medical, scientific, promotional, or educational purposes provided **my identity is not revealed** in the process.

_____ (initial) I give permission to be on Snapchat

I further agree to hold Angelo A. Tellis M.D. and Aegean Medical staff free and harmless from all claims arising from the use of said photographs, audio, and video recordings when used within the scope described above.

_____	_____	_____
Patient Signature	DOB	Date

_____	_____
Witness Signature	Date

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