

# LIPOSUCTION

I authorize **Dr. Robert Hunsaker** and such associates and assistants as he may designate, to perform upon me the surgical procedure known as **liposuction**. I acknowledge that I have requested that this elective surgical procedure be undertaken in an attempt to change the current contour of my(circle those applicable): neck, arms, abdomen, flanks, back, hips, inner thighs, outer thighs, anterior thighs, knees, calves, other \_\_\_\_\_.

I am aware that the practice of surgery is not an exact science and I acknowledge that **NO GUARANTEES** have been made to me as to the final results of the procedure to be performed. I am aware that there are risks, consequences and complications associated with all surgery and medical treatment and these have been explained to me and all my questions have been answered.

I understand that **SOME** of the risks, consequences and complications **MAY** include but are **NOT LIMITED** to:

Bleeding, infection, wound healing problems, permanent scars, permanent pigment changes, permanent numbness, fat embolism, shock, swelling, blood clots, skin irregularities, skin depressions and/or bulges, loose skin, asymmetry, personality changes including depression, anxiety, and/or dissatisfaction with results, allergic reactions, and death. **FURTHERMORE**, I completely understand and accept that further surgery of the same or different type may be necessary to achieve the final desired result, AND that it may be impossible to completely meet my expectations. I understand that if further surgery is desired that, while there **MAY** be special consideration given for professional fees, there **WILL BE ADDITIONAL CHARGES** in order to cover costs of O.R., personnel, supplies, etc. Additionally, I am fully aware that there may be alternative treatments available to me such as accepting my present condition, losing weight and/or exercising. Liposuction is **NOT a treatment for obesity!**

I recognize that during the course of the operation unforeseen circumstances may arise and I request the surgeon to use his best judgment to provide whatever care he feels is in my best interest at the time **even if this requires additional and/or different procedures than set forth above.**

I understand that my closely following all pre and post operative instructions regarding care and restrictions is a **VITAL** part of determining my final result.

**I HAVE READ THE ABOVE AND UNDERSTAND ALL PORTIONS AND HAVE HAD ALL MY QUESTIONS SATISFACTORILY ANSWERED. I UNDERSTAND AND ACCEPT ALL THE POSSIBLE RISKS, CONSEQUENCES AND COMPLICATIONS OF THE ABOVE NAMED PROCEDURE(S).**

WITNESS \_\_\_\_\_

PATIENT \_\_\_\_\_

WITNESS \_\_\_\_\_

DATE \_\_\_\_\_

I understand that, by law, a choice of anesthesia providers exists, i.e., anesthesiologist, certified nurse anesthetist, other appropriately trained physician, or physician assistant qualified as set forth in rule 64B8-30.012(2)(b)6., Florida Administrative Code.

This doctor's office is regulated pursuant to the rules of the Board of Medicine as set forth in Rule Chapter 64B8, Florida Administrative Code.