

**BREAST AUGMENTATION**

I authorize **Dr. Robert Hunsaker** and such associates and assistants as he may designate, to perform upon me the surgical procedure known as **BREAST AUGMENTATION**. I acknowledge that I have requested that this elective procedure be undertaken in an attempt to enlarge my breasts. 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 possible complications associated with all surgery and medical treatment. The significant and most common risks of my surgical procedure and anesthesia have been explained to me and all of my questions have been adequately 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 change in nipple sensation, interference with mammograms, inability to breast feed, pain, asymmetry, implant malposition, implant leakage, visible implant, wrinkling/rippling, severe capsular contracture, synmastia, swelling, bruising, blood clots, personality changes including depression, anxiety and/or dissatisfaction with results, allergic reactions, collapsed lungs 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 this implant is **NOT** to be considered a permanent device and that further surgery may be desired and/or required on my breasts in my lifetime – whether related to my implants or not. I understand that if further surgery if desired/required, that while there **MAY** be special consideration given for professional fees, **THERE WILL BE ADDITIONAL CHARGES** to cover costs of O.R., personnel, supplies, implants, anesthesia, etc. Additionally, I am fully aware that there may be alternative treatments available to me such as accepting my present condition, breast lift surgery or prosthesis. I recognize that during the course of the operation unforeseen circumstances may arise and I request that the surgeon use his best judgment to provide whatever care he feels is in my best interest at the time even if **this requires additional and different procedures than set forth above.**

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

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

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 F Medicine as set forth in Rule Chapter 64B8, Florida Administrative Code.