INFORMED CONSENT FOR

STEROID INJECTION
5 FLUOROURACIL (5FU) INJECTION

(PLEASE READ THIS DOCUMENT, INITIAL THE BOTTOM OF EACH PAGE AND SIGN THE LAST TWO PAGES)

PATIENT NAME _____

KAROL A GUTOWSKI, MD

_____

_____

(THE PHYSICIANS)

PATIENT INITIALS _____

CONSENT FOR STEROID OR 5-FLUOROURACIL INJECTION

INSTRUCTIONS

Being fully informed about your condition and treatment will help you make the decision whether or not to undergo a steroid or 5-floururacil (5FU) injection is disclosure is not meant to alarm you; it is simply an effort to better inform you so that you may give or withhold your consent for this 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 this procedure.

ALTERNATIVE TREATMENTS

Alternative treatments may include scar or lesion excision, laser treatment, or no treatment at all.

Discomfort – These injections may be uncomfortable or even painful during the injection.

Unsatisfactory result - There is the possibility that you may be unhappy with the result.

Allergic reactions - As with all products, allergic and systemic anaphylactic reactions may occur. Allergic reactions may require additional treatment.

Infection - Infection is extremely unlikely after nipple procedures. Should an infection occur, additional treatment including antibiotics may be necessary.

Need for multiple treatments – In most cases, more than one treatment is needed to achieve a result.

Discoloration – In some cases, the skin may become darker, or lighter. This is usually temporary but may be permanent.

Fat and skin thinning (atrophy) – It is common for the skin or fat in the injection area to become thinner. This is usually temporary but may be permanent.

Wounds & ulcers – Very rarely, a wound may develop at the injection site and may require more treatment.

Bruising & Bleeding – There may be a small amount of bruising or bleeding after the injection.

Infection – Although very rare, an injection may occur at the injection site and require treatment.

Telangiectasias – Small red or purple blood vessels may appear at the injection site. These are usually temporary but may be permanent.

Hair thinning – Hair in the injection area may become thinner. These are usually temporary but may be permanent.

CONSENT FOR STEROID OR 5-FLUOROURACIL INJECTION

HEALTH INSURANCE

Most health insurance companies exclude coverage for cosmetic surgical procedures and treatments, or any complications that might occur from the same. Please carefully review your health insurance subscriber information pamphlet.

FINANCIAL RESPONSIBILITIES

This procedure is typically not covered by insurance so you are responsible for all costs.

DISCLAIMER

Informed-consent documents are used to communicate information about the proposed treatment of a 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.

Informed-consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined based on all 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 your questions answered before signing the consent on the next page.

CONSENT FOR SURGERY/ PROCEDURE or TREATMENT

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

Steroid and/or 5-Flourouracil injection

I have received the following information sheet:
INFORMED-CONSENT for Steroid Injection

INFORMED-CONSENT for 5-Fluorouracil Injection

2. I recognize that during the course of the procedure, unforeseen conditions may necessitate different procedures than those above. I therefore authorize The Physicians and assistants or designees to perform such other procedures that are in 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 involve 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 video recording 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 METHODS OF TREATMENT
   c. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED
10. I READ AND UNDERSTAND THIS DOCMENT. I ACCEPT THE RISKS EXPLAINED IN THIS DOCUMENT.

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-10). I AM SATISFIED WITH THE EXPLANATION.

_____

Patient or Person Authorized to Sign for Patient

Date _____ Witness _____

Patient Initials _____

AUTHORIZATION & CONSENT FOR RELEASE OF MEDICAL IMAGES

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by The Physicians or their representatives.

INTRODUCTION

For your medical records, images (photographs, slides, videos, interviews or any other images of you, or components of your medical record) may be taken before, during, or after a surgical procedure or treatment. These images may be needed to document your medical condition, used as supporting material for authorizing medical coverage and payments, and treatment planning. Consent is required to take, use and release such images. Since The Physicians are also educators of other physicians, researchers, and healthcare professionals, your images may be used for other purposes as described below.

1. CONSENT TO TAKE PHOTOGRAPHS, SLIDES, DIGITAL IMAGES, AND VIDEOTAPES

I hereby authorize The Physicians and/or their associates to take any images before, during and after my treatments or surgeries.

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize The Physicians and/or their associates to use any of these images for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks including the internet, print or visual or broadcast media, for purposes of examination, testing, credentialing and/or certifying purposes for medical education, patient education, lay publication, or during lectures to medical or lay groups, for marketing and advertising, and for use in medical teaching, research or dissemination of medical information to medical and nonmedical audiences, including, but not limited to, journal or book publications, presentations, conferences, and print marketing material (magazine, newspaper, etc) or electronic media (television, internet, etc).

3. CONSENT FOR RELEASE TO PROFESSIONAL ORGANIZATIONS

I further authorize The Physicians or to release to the American Society of Plastic Surgeons (ASPS), the American Society for Aesthetic Plastic Surgery (ASAPS), and the American Board of Plastic Surgery (ABPS) such images. I provide this authorization as a voluntary contribution in the interests of public education. The images may be used for publication in print, visual or electronic media, specifically including, but not limited to, medical journals (such as *Plastic and Reconstructive Surgery, Annals of Plastic Surgery, Aesthetic Plastic Surgery)*, textbooks, lay publications, patient education or during lectures for the purpose of informing the medical profession or the general public about plastic surgery methods, medical education or examination material by ASPS, ASAPS, and ABPS. I understand that such images shall become the property of ASPS, ASAPS, and ABPS, and may be retained or released by these organizations for the limited purpose mentioned above. I also grant permission for the use of any of my medical records including illustrations, photographs, video or other imaging records created in my case, for use in examination, certifying and/or re-certifying purposes by ABPS.

I understand that I will <u>not</u> be identified by name in any release of these materials but in some cases the images may contain features that may make my identity recognizable. I release and discharge The Physicians and all parties acting on their authority from all rights that I may have in these images, and from any claims that I have related their use in the above mentioned manner.

I also release The Physicians and any employees or agents from all liability, including any claims of libel or invasion or privacy, directly or indirectly connected with, arising out of or resulting from the taking and authorized use of these images or recorded interviews.

I understand that I have the right to request cessation of recording or filming at any time. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and /or my interview.

Patient Name _____
Patient Signature _____ Date _____
Witness or Guardian/Parent_____ Date _____