

PLASTIC SURGERY CENTER OF ST. JOSEPH, INC.  
MICHAEL D. DE PRIEST, M.D.

CONSENT FOR LIPOSUCTION

PATIENT'S NAME: \_\_\_\_\_

DATE OF SURGERY: \_\_\_\_\_

1. I authorize Dr. Michael De Priest to perform lipoplasty or liposuction. Dr. De Priest has explained the operation to me. I understand that this procedure is to contour my body by reducing localized accumulations of fat. This is not a treatment for general obesity. This procedure is purely elective.
2. I am aware that the practice of medicine and surgery is not an exact science. I know that there are no guarantees regarding the results of the operation, permanency of the results, or my satisfaction with the results.
3. The following are expected results of liposuction:
  - a. Permanent scars at the incision sites.
  - b. Improved body contour-but without a change in skin quality or laxity.
  - c. Improved appearance both in and out of clothing.
  - d. Improved body proportions in the treated area(s).
4. I understand that every surgical procedure involves certain risks and the possibility of complications such as bleeding, infection, poor wound healing, etc. Complications may follow this operation, even when the surgeon uses the utmost care, judgment, and skill. The list below contains several (but not all) possible complications that can follow liposuction. The doctor and nurse have discussed these points to my satisfaction, and I accept the risk of their occurrence.
  - a. Shock requiring transfusion
  - b. Fluid collections--either a seroma or hematoma
  - c. Infection
  - d. Skin loss
  - e. Remote possibility of pulmonary fat embolism.
5. I recognize that during the course of the operation, unforeseen conditions may necessitate additional or different procedures than those explained. I further authorize and request that Dr. De Priest perform such procedures as are, in his professional judgment, necessary

and desirable. The authority granted under this paragraph shall extend to remedy conditions that are not known to (or could not reasonably be anticipated by) Dr. De Priest at the time of the operation. This may include transfer and admission to a hospital.

6. I consent to the administration of anesthetic agents by the surgeon. I consent to the administration of intravenous anesthetic agents by or under the direction of the surgeon. I accept this risk of anesthesia and agree to discuss any questions I have concerning anesthesia with the surgeon.
7. If I need a general anesthetic, trained anesthesia personnel working with Dr. De Priest will administer it. I understand that the use of a general anesthetic presents additional risks over which Dr. De Priest has no control. I accept this risk and agree to discuss any questions I have concerning anesthesia with the anesthesia personnel prior to surgery.
8. I consent to photographs before, during and after the procedure. These photographs shall be the property of Dr. De Priest. The photos are confidential.
9. I agree to keep Dr. De Priest informed of any change in my address and phone number, and I agree to cooperate with him after surgery until completely released.
10. I have read the above consent. I understand the contents and have had the opportunity to ask questions concerning it. I request and authorize Dr. De Priest to perform liposuction on me. I have also received and studied the informational brochure on this procedure.

**PATIENT SIGNATURE:** \_\_\_\_\_

**WITNESS SIGNATURE:** \_\_\_\_\_

**M.D. SIGNATURE:** \_\_\_\_\_

**DATE SIGNED:** \_\_\_\_\_