TOM J. POUSTI, MD, F.A.C.S.

PLASTIC AND RECONSTRUCTION SURGERY

CONSENT FOR SURGERY/ PROCEDURE OR TREATMENT

1. I hereby authorize Dr. Tom Pousti and such assistants as may be selected to perform the following procedure or treatment upon :_____

   I have received the following information sheet:
   INFORMED-CONSENT for LABIA REDUCTION SURGERY

2. I recognize that during the course of the operation and medical treatment or anesthesia, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above physician and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgement 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 risks 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 disposal of any tissue, medical devices or body parts, which may be removed.

6. I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical-device registration, if applicable.

7. I understand that additional fees may apply in the case that further (revisionary) surgery is needed.

8. 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 PROCEDURES OR METHODS OF TREATMENT
   c) THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED
   d) THERE MAY BE ADDITIONAL FEES FOR FURTHER (REVISIONARY) SURGERY

I CONSENT TO THE TREATMENT OF PROCEDURE AND THE ABOVE LISTED ITEMS. I AM SATISFIED WITH THE EXPLANATION.

Patient or Person Authorized to Sign for Patient Date