FACELIFT

(Rhytidectomy)

While the patient is sedated, the plastic surgeon makes incisions above the hairline at the temples, behind the earlobes, and (possibly) to the lower scalp. In general, the surgeon then tightens the underlying muscle and membrane, may remove some of the fat tissue and loose skin, and stitches the incisions closed. The membrane is called the SMAS layer and assists in the lifting portion of the facelift.

I authorize and direct **Dr. Jeffrey Raval, M.D.** with associates or assistants of his choice, to perform a facelift on _____. (Patient's name)

I further authorize the physician and assistant(s) to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

(Patient's Initials)

_____ The details of the procedure have been explained to me in terms I understand.
_____ Alternative methods and their benefits and disadvantages have been explained to me.
_____ I understand and accept possible risks and complications including, but not limited to:

- Bleeding (requiring hospitalization)
- Infection
- Hematoma
- Scarring
- Numbness
- Nerve damage
- Asymmetry
- Loss of skin or hair
- Discoloration
- Unsatisfactory results

_____ I understand and accept the less common complications, including the remote risk of death or serious disability that exists with any surgical procedure.
_____ I understand that tissue cannot heal without scarring and that how one scars is dependent on individual genetic characteristics. The physician will do his best to minimize scarring, but cannot control its ultimate appearance.
_____ The placement of incisions and resulting scars has been explained to me.
_____ I have been informed that the nerves that control the muscles of facial expression can on rare occasions be slow in recovering.
_____ I am aware the smoking during the pre- and postoperative periods could increase chances of complications.
_____ I have informed the doctor of all my known allergies.
_____ I have informed the doctor of all known medical conditions I have been diagnosed with.
_____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the counter remedies, herbal therapies, and any other.
_____ I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.

_____ I have or will discontinue oral contraceptives.
_____ I am aware and accept that no guarantees about the results of the procedure have been made.
_____ I have been informed of what to expect post-operatively, including but not limited to: estimated recovery time, anticipated activity level, and possibility of additional procedures.
_____ I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation.
_____ Pre- and post-operative photos and/or videos will be taken of the treatment for record purposes. I understand that these photos and/or videos will be the property of the attending physician and will only be used as part of my medical record.
____ I understand I will be required to return to the office for post operative appointments 24 and 48 hours after surgery, and 7 and 10 days after surgery.
____ I agree to the physician or nurse administering a local anesthetic nerve block prior to treatment if necessary for pain relief.
____ I accept responsibility for any complications that may occur and thereby absolve Raval Facial Aesthetics and any associated person of blame resulting there from.
____ I understand that the terms of payment require full settlement prior to the day of my procedure.
_____ The doctor has answered all of my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

Patient Signature/Date

Witness Signature/Date

I certify that I have explained the nature, purpose, benefits, risks, complications, and alternatives to the proposed procedure to the patient. I have answered all questions fully, and I believe that the patient fully understands what I have explained.

Physician Signature/Date

Copy given to patient: _____
Original placed in chart: _____