Treasure Coast Hair Restoration
Consent for Hair Transplantation Procedure

(Please underline any portion of this consent you want explained)

1. I, _____, hereby give consent to Dr. Adam Kurtin and his hair transplantation team to have hair replacement surgery performed upon me. I also consent to any other medical services during the procedure that may become medically reasonable and necessary. This includes, but is not limited, the administration of anesthetics and/or sedatives necessary to perform a hair transplant procedure.
2. I am aware that good results will depend in part upon my completing the necessary number of operations recommended by the doctor. However, because many variables exist, I have not been promised or guaranteed good results. I also understand that the quality and amount of preexisting hair are major factors in ultimate result. I understand I will not have hair of the same thickness/density as I had prior to the onset of my hair loss.
3. Prior to my consenting to cosmetic surgery, I state I have read or have been given the opportunity to review literature available to me that may include:
   - Brochure
   - Review of website
   - List of complications
   - Preoperative and post operative instructions
   - Fee schedule per session
4. I fully understand the results that I may reasonably expect. I understand hair transplants are not perfect. An explanation of this procedure has been given to me. I have had the opportunity to ask any questions regarding this procedure. I do understand that I will not obtain a full head of hair from the procedure. I understand that visibility of the sites following a transplant surgery can last for a number of days.
5. The pros, cons, and alternatives to hair transplantation have been explained. I have the option of doing nothing, wearing a hairpiece/wig, using prescription medication or having a transplant surgery or other type of scalp surgery procedure. A combination of the above is also possible. I have been informed of all options.
6. It is suggested I receive _____ session(s) of grafts as a minimum. I understand that more operations may be recommended later due to ongoing loss of my non-transplanted hair. I understand that all recommendations made during my consultation and treatment are estimates and may change later._____(Initial) If the doctors or I feel an additional procedure is necessary, I understand there will be additional surgical fees.
7. I understand every time an incision is made in the human body, a scan will occur, although every effort will be made to make the scan inconspicuous. Superficial crusting, pinkness, or redness of the incision area may occur, but these will likely be temporary. A thickened or raised scar (a hypertrophic scar/keloid) is possible. This is more likely to occur in patients with a history of this type of scarring. Wide scarring is also possible in the doctor area.
8. I have been informed that hair transplantation is generally a safe procedure, however I am aware that complications may occur. The more common complications and a partial list of rare complications of this surgery have been explained to me and/or I have reviewed a list of them provided which I signed and dated. A copy of that list is attached. Unforeseen, rare complications, such as unanticipated reaction to medications and anesthetics, uncommon infections, and unusual healing responses, are possible. Every unforeseen complication may not have been discussed with me in detailed, but I do understand that such risk does exist.
9. I consent to and authorize the performance of hair transplant surgery by Treasure Coast Hair Restoration, associate doctors, and hair transplant technicians.
10. I believe I have been well informed. I understand that good results are expected, but the practices of medicine and surgery are not exact sciences. I understand knowledgeable practitioners sometimes disagree as to the best methods of treatment to achieve desired results.
11. It has been explained to me that the amount and location of future hair loss on the scalp, including the sides and back area cannot be predicted. I do understand it is possible to lose my existing hair at any point in the future. I do understand this may affect the appearance of the grafted area. Hair transplants may not be permanent. They are usually very long lasting, but rarely have fallen out in one to ten years.

12. There is a possibility of some temporary hair loss in the back of the scalp surrounding the area where the donor strip was removed. In rare cases, there may be permanent loss of hair adjacent to the surgical incision. In the transplanted area shedding of existing hair, called surgical effluvium, may occur after the surgery. If this hair is at the end of its normal life span, it may not return.\
13. I understand the success of the hair transplant procedure is dependent upon my closely following all instructions. This includes, but is not limited to, pre-operative and post-operative activities and precautions, which have been explained to me. I have also received a written copy of these instructions.
14. This consent was read and signed while I was not under the influence of medications that might alter my mental capacity to understand this consent.
15. I certify this form has been read or it has been read to me, the blank spaces have been filled in, and I understand its contents.
16. I have disclosed all information regarding past and present medical conditions, current medications, and known drug allergies. This information is necessary so that the proper medical treatment is given at all times during the transplant procedure.

Some postoperative discomfort may be experienced. _____(Initial)

I acknowledge that I am responsible for payment of these with no fee reimbursement regardless of procedure results. I understand the fee paid is for the procedure and not for an expected result.

Date:_____ Time:_____am/pm

_____
Patient or Other Legally Responsible Person

_____
Patient Name – Printed

_____
Witness

Possible Complications

- Nausea and vomiting from pain medication
- Bleeding (less than 5%)
- Infection (less than 1%)
- Excessive swelling
- Temporary headache
- Temporary numbness of the scalp
- Scarring around the grafts
- Poor growth of grafts
- Reach to medications (less than 1%)
- Fainting (less than 1%) or syncope episodes
- Occasional small-ingrown hairs – causing a cyst (less than 10%)
- Scarring of the donor area – wide scars are possible (less than 5%)
- Bruising

(Patients who smoke have a higher rate of delayed wound healing and lower graft yield. Smoking not recommended for 2-3 weeks prior to and following the procedure.

Rare Complications (Partial List Only)

- Keloid formation
- Complete failure of growth of transplanted hairs
- Persistent scalp pain
- Total loss of donor hair
- Permanent numbness of the scalp
- Noticeable scarring of donor area

- Loss of transplanted hair
- Allergic reaction or medication-related problem

I have read and understand all of the possible complications listed above. I accepted the risks of these possible complications and consequences associated with this surgery.

_____

Patient Signature Date

_____

Witness Date

FOR PATIENTS WHO HAVE HAD PRIOR TRANSPLANTS WITH ANOTHER PHYSICIAN:

I acknowledge that that prior to contacting Dr. Adam Kurtin at Treasure Coast Hair Restoration, I received transplants or scalp reductions from another physician. I further acknowledge that Dr. Adam Kurtin, Treasure Coast Hair Restoration, its physicians and employees bear no responsibility for my present condition. I have been informed that my condition cannot be completely restored to its original state prior to any transplant surgery._____(Initial)

Consent for anesthesia services

1. All forms of anesthesia involve some risk and no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare and unexpected severe complication with anesthesia can occur and include the remote possibility of infection, bleeding, drug reaction, blood clots, loss of sensation, loss of limb function, par4alysis, stroke, brain damage, hear attack, or death.
2. I understand the type of anesthesia service (listed below) will be used for my procedure and that the anesthetic technique to be used will be determined by many factors including my physical condition, the physicians' preference, as well as my own desire.
3. Nerve block anesthesia is highly effective and generally safe. In rare cases though, there have been reports of nerve damage. The instances are approximately 1:30,000. Most cases resolve on their own and do not require treatment.

Anesthesia to be used: **Major/Minor Nerve block without sedation**

Expected results: Temporary loss of feeling and/or movement of a specific area.

Technique: Drug injected near nerves providing loss of sensation to the area of the operation.

Risks: Include but are not limited to, infection, convulsions, weakness, persistent numbness, residual pain, injury to blood vessels, or nerve injury.

I hereby consent to the anesthesia service described above and authorize its administration by Dr. Adam Kurtin and/or his associates. I also consent to an alternative type of anesthesia if necessary and deemed appropriate.

I certify and acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia services and that I had ample time to ask questions and consider my decision.

Patients' Signature or Other Responsible Party Date/Time

_____

Witness Date