HAIR RESTORATION CENTER OF CONNECTICUT

INFORMED CONSENT FOR HAIR RESTORATION PROCEDURE

(Please Initial)

_____1. This **Consent** for Operation and Photography (hereinafter "Consent") is executed this ____ day of _____ (month), _____ (year), by_____. By executing this Consent, the Patient requests and authorizes Dr. Scott Boden to proceed with hair restoration surgery, and to perform other medically necessary services required to complete this surgery and render appropriate care to the Patient. The Patient further requests and authorizes the use of other medical personnel, including nurses, medical technicians and assistants, to provide medically necessary services, under the direction of Dr. Boden, associated with the hair restoration process and surgery.

____2. **My Informed Decision:** By signing this consent, the Patient acknowledges that the hair restoration process, including the actual hair restoration surgery, has been explained to him/her by Dr. Boden. The patient further acknowledges an understanding of the hair restoration process, including hair restoration surgery, reasonable expectations of hair density, and possible desire for additional procedures in the future. The Patient further acknowledges that he/she has had the opportunity to ask questions about the hair restoration process and surgery, and that Dr. Boden has addressed all issues concerning the hair restoration process that the Patient may not have initially understood. All alternatives of hair restoration surgery have been explained and are understood (doing nothing; wearing a hair-piece or using other cosmetic adjuncts; using prescription and non-prescription medications; using laser therapy to stimulate hair growth; or a combination of the above options). The Patient further acknowledges and agrees that he/she has been advised that as with any medical procedure, there are risks which stem from hair restoration surgery. These risks include, but are not limited to scarring (from hypertrophy, stretching, or other mechanisms), temporary bleeding, infection, pimples, swelling, stretching, shock loss (temporary shedding of some of the existing hair), redness, numbness and tingling.

____ 3. **Unforeseen Conditions:** The Patient recognizes that during the course of a medical procedure, unforeseen events may necessitate medical treatment in addition to any procedures stemming from, or associated with, hair restoration services. With this is mind, the Patient authorizes Dr. Boden as well as all other medical personnel working under the supervision of Dr. Boden, to perform all medically necessary procedures required to treat, relieve or palliate any unforeseen condition occurring during the course of medical hair restoration surgery.

____4. **Anesthesia, Medications and Allergies:** The Patient understands that the most common medications used during hair restoration surgery are local anesthetics, with oral medications to relieve anxiety. The patient consents to the administration of medications to include, but are not limited to: anesthetics, anti-anxiety medications, antibiotics, and analgesics.

- I understand that I may be given medications that could temporally affect by ability to drive and that if the physician advises I will arrange for other transportation.
- To the best of my knowledge I am or may be allergic to:

  _____.

  (Write NONE if no allergies are known)

Patient name: _____ Date:_____

_____5. **Medicine is an Art:** The Patient acknowledges that he/she has been advised about the possible outcomes of the hair restoration process and surgery, realistic expectations of density, and that he/she has been advised that additional surgeries may be required in order to obtain a degree of hair growth that the Patient ultimately desires. A proposed hair transplant plan will be reviewed with you prior to the beginning of your procedure, and photographs will be taken. Every effort will be made to meet this proposed surgical plan.

_____6. **Risk Management:** I also consent and agree to allow my blood to be tested for potential infectious agents (Hepatitis and/or HIV) in the event that medical personnel, although using prudent and universal precautions, inadvertently become exposed to my blood.

_____7. **Photography:** Dr. Boden will preserve for my medical records and teaching purposes any and all of my photographs.

Initial Below:

_____ I hereby authorize Dr. Boden to utilize for in-office consultation any and all of my photographs.

_____ I hereby authorize Dr. Boden to utilize for public/promotional campaigns any and all of my photographs.

I certify that I have read and fully understand the provisions of this form, and consent to the above listed procedures and photography and that the explanations therein referred to were made and that all the blanks or statements requiring insertions were completed and the appropriate items or paragraphs, if any, were stricken.

Patient Signature: _____Date: _____

Witness Signature: _____Date: _____

Physician Signature: _____Date: _____

Patient name: _____