

Curtis SF Wong, MD, Inc.
2440 Sister Mary Columba Dr.
Suite 200
Red Bluff, CA 96080
(530) 690-2424

Consent for Surgery/Procedure or Treatment

I hereby authorize Dr. Curtis SF Wong and such assistants as may be selected to perform the following procedure or treatment: Vertical Tummy Tuck

I have received the following information sheet: General Risks of Surgery and Informed Consent-Abdominal Contouring/Abdominoplasty

I recognize that during the course of the operation and medical treatment or anesthesia, unforeseen conditions may necessitate different procedures than those specifically listed above. I therefore authorize Dr. Curtis Wong and assistants to perform such other procedures that are in the exercise of his professional judgment 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.

I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involve risk and the possibility of complications, injury, and sometimes death.

I understand what my surgeon can and cannot do, and I understand there are no warranties or guarantees, implied or specific about my outcome. I have had the opportunity to explain my goals and understand which desired outcomes are realistic and which are not. All of my questions have been answered, and I understand the inherent (specific) risks of the procedures I seek, as well as those additional risks and complications, benefits, and alternatives. Understanding all of this, I elect to proceed.

I consent to be photographed or videotaped before, during and after the operation(s) and procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes provided my identity is not revealed by the pictures (i.e.: full face).

For the purposes of advancing medical education, I consent to the admittance of observers to the operating room such as nursing students, medical students, and medical residents.

I consent to the disposal of any tissue, medical devices or body parts which may be removed. Another waiver will be signed if this is anticipated such as with breast lifts where minimal tissue is removed.

I consent to the utilization of blood products should they be deemed necessary by my surgeon and his appointees, and I am aware there are potential significant risks to my health with their utilization.

I authorize the release of my social security number to appropriate agencies for legal reporting and medical-device registration if applicable.

I understand that the surgeon's fees are separate from the anesthesia and hospital/facility charges, and the fees are agreeable to me. If a secondary procedure is necessary, further expenditure will be required.

I realize that NOT having the operation is an option.

**It has been explained to me in a way that I understand:
the above treatment or procedure to be undertaken/done
there may be alternative procedures or methods of treatment
there are risks to the procedure or treatments proposed.**

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

Patient or person authorized to sign for the patient

Date: January 18, 2011

Witness: _____