Lipotherme

Informed Consent for Treatment

This is a doctor's office regulated pursuant to the rules of the Board of Medicine as set forth in Rule Chapter 64B8, F.A.C.

Patient Name _____ Date_____
Procedure _____
I _____ herby request and authorize Dr. Alberico J. Sessa to perform Lipotherme Laser-Assisted lipolysis on my _____.

I understand the Lipotherme laser is an FDA cleared device. I have had time to discuss my indications and the treatment with my physician and all of my questions have been answered to my satisfaction. I have adequate knowledge of the procedure to sign an informed consent for surgery.

I understand that treatment is contraindicated in patients currently taking anti-coagulants, active skin infection, compromised immune system, impaired healing, pregnant or have serious medical problems.

I consent to the administration of anesthesia by my Doctor or other qualified staff as needed during the surgery. I understand that all anesthetics involve risks of drug reactions and complications.

I understand that the Lipotherme is a laser and is an instrument used to enhance conventional liposuction.

I understand that clinical results may vary depending on my response to surgery and my compliance with pre and post treatment instructions.

I also understand that possible complications and risk include scarring and atrophy to the tissue, infection, swelling and prolonged redness of the treated skin.

I consent to taking photographs and authorize their anonymous use for public education, medical study or research and documentation for my medical records.
_____ (Patient Initials)

I do not consent to photographs _____ (Patient Intitals)

I understand and will follow the Doctor's recommendations for post treatment of the areas being treated.

I understand that no guarantee has been given to me with regard to the percentage of improvement and that more than one treatment may be necessary to achieve the desired results.

Patient (Print Name) _____

(Signature) _____ Date _____

Witness (Print Name) _____

(Signature) _____ Date_____

CONSENT FOR SURGERY

This is a doctor's office regulated pursuant to the rules of the Board of Medicine as set forth in Rule Chapter 64B8, F.A.C.

Recent changes in legal doctrine require us to discuss with you in the fullest possible way the details of your proposed surgery. What you are being asked to sign is simply a confirmation that we discussed your proposed operation and that we have given you sufficient information upon which to arrive at a decision of your own free will. We have already discussed with you the common problems that sometimes occur. We wish to inform you, not alarm you. If you wish, however, we can go into elaborate details of extreme unlikely problems. If you do not, that is also your right. Please read the form carefully and check the appropriate boxes. Ask about anything you do not understand. We will be happy to explain it.

1) I hereby authorize Dr. Alberico J. Sessa to perform upon me:

O **Liposuction of the Abdomen** (removal of excess fat from my abdomen using laser-assisted lipolysis)
O **Liposuction of Lovehandles** (removal of excess fat from my lovehandles using laser-assisted lipolysis)
O **Liposuction of Hips/Lower back** (removal of excess fat from my hips/lower back using laser-assisted lipolysis)
O **Liposuction of Face** (removal of excess fat from my face using laser-assisted lipolysis)
O **Liposuction of Thighs** (removal of excess fat from my thighs using laser-assisted lipolysis)
O **Liposuction of Arms** (removal of excess fat from my arms using laser-assisted lipolysis)
O Other ( )

2) If any unforeseen conditions arise during the course of the operation or at any time thereafter including the possible need for further revision which you have fully explained to me, I do hereby authorize and request him and/or such other physicians to take whatever steps, and to perform whatever procedures he deems advisable, in his sole discretion which may be in addition to or different from those now planned, and acknowledge that there may be additional cost for any additional procedure or hospitalization that may be required.

3) I acknowledge that Dr. Sessa has explained to me the general method of procedure, and he has also explained to me that there are always certain risks and consequences of the procedure. These, among others, are scarring and possible damage to blood vessels, or parts next to them, such as nerves or allergic reactions, or heart, brain, kidney liver or lung complications and death. I understand that there is no way to make a scar disappear completely and that it is even possible that it will be worse after the operation.

4) I acknowledge that no guarantee or assurance whatsoever has been made or indeed can be made to me as to any of the results or risks, since the practice of medicine is not an exact science; I assume all risks of the proposed procedure.

5) I hereby request and authorize the transfusion or administration of blood and blood components and drugs to me during my surgery at the hospital or office.

***** I understand that the policy in this office is to have no cell phone, jewelry, or any valuables of any kind when I come for surgery. If I choose to conceal these items and they are misplaced or lost, Dr. Sessa's facility carries no responsibility whatsoever for these items.**

6) I authorize the taking of photographs before and after this procedure for the purpose of advancing medical education. I further understand that these photographs are the sole property of Dr. Alberico J. Sessa, employees and agents for advertising, marketing and promotions with no prior approval by me, the patient. I further agree to release Dr. Alberico J. Sessa, his clients, officers, employees and agents of and from all debts, claims and liabilities of any caption or descriptive material therewith.

7) I authorize the medical personnel to do any other procedure that their judgment may dictate to be advisable for my well being. The details of the operation have been explained to me. Alternative methods of treatment, if any have been explained to me, as have been the advantages and disadvantages of each. I am advised that though good results are expected, not all complications can be anticipated and that therefore there can be no guarantee or assurance either expressed or implied, as to the results of the surgery. I acknowledge that Dr. Sessa has explained to me the most likely complications or problems that might occur in this operation and during the healing period, and I understand them.
Dr. Sessa has offered to explain to me in detail any complications which, even rare, could occur. I acknowledge that I have been given full information about any complications or problems that I wish to have information about.

8) I acknowledge the Dr. Sessa had offered me the opportunity of fully reviewing this request form with my personal physician and my legal advisor, to make certain that I fully understand and appreciate this request. I acknowledge that one of the reasons for the delay between the date of signing this request and the date the procedure is scheduled to be performed is to allow me the opportunity for obtaining any further or additional information I may desire about the proposed procedure, or any complications, problems, or side effects that may arise from it whatever source, including obtaining a second opinion or any other information.

9) I consent to the disposal of any tissue or parts which may be removed.

10) I CERTIFY THEAT I HAVE READ AND UNDERSTAND the foregoing and had the contents of the foregoing explained to me. I fully understand this request for surgery and I fully understand the procedure. The following, among others have specifically been made clear to me regarding possible complications and unfavorable results.

11) I have been advised that all surgery involves general risks, including but no limited to bleeding, infection, nerve or tissue damage and, rarely, cardiac arrest death, or other serious bodily injury.

12) I further acknowledge that the unusual risks and hazards of both the surgical procedure(s) and necessary anesthetic were made known to me and that I accept full responsibility for these or any other complications which may arise or result during the surgical procedure(s) which is to be performed at my request according to this consent. Some of the complications of this operation may cause the need for further surgery and therefore, additional costs to me.

13) I consent, authorize and request the administration of such anesthetics as is deemed suitable by the anesthesiologist who is an independent contractor and consultant. I fully understand that the anesthesiologist will have full charge of the administration and maintenance of the sedation or general anesthesia and that this function is independent from the procedure, and that Dr. Sessa has no responsibility for direct control over the administration of the anesthetic during the procedure(s) and I have been fully informed and understand that my exposure to anesthesia may result in adverse consequences, such as paralysis, coma or prolonged coma, local paresthesia, pneumonia, vocal cord paralysis, broken or fractured teeth, hepatitis and possible death.

I CERTIFY: I have read or had read to me the contents of this form; I understand the risks and alternatives involved in this procedure and authorize the procedure. All blanks have been filled prior to my signature.

Patients Signature: _____ Date: _____
(Signed by patient or person legally authorized to consent for patient)

Witness Signature: _____ Date: _____

NOTE: In case of an emergency, please provide us with a name and number of the person you would like for us to contact:
EMERGENCY CONTACT: _____ ( ) _____
RELATIONSHIP TO PATIENT: _____

Liposuction
Postoperative Instructions

* Your body will often leak large volumes of fluid in the first day after surgery. This is normal and expected. I encourage patients to prepare for this by laying down trash bags on the bed, and then followed by multiple layers of absorbent towels. Get up slowly to use the bathroom and use assistance for the first day or so.

It will be necessary for you to wear a girdle-like garment 24 hours a day for six to eight (6-8) weeks after surgery. (Unless told otherwise)

The garment should not be removed until *24 hours* after surgery.

After 24 hours you may remove the garment for a brief period to shower. Do not take a bath until sutures are out.

There may be a few sutures at each site the tube was inserted for suction. These will be removed in seven to ten (7-10) days.

Be sure you have received a prescription for pain medicine before you leave the office. Take only as directed.

Do not take aspirin-containing products. These can cause bleeding. Your pharmacist can tell you which medicines contain aspirin. **Do Not** Take Ibuprofen.

Swelling and bruising may be extensive. This is normal and will gradually subside within 2-3 weeks.

Numbness is not uncommon in the suctioned areas. You are advised to avoid excessive heat such as heating pads until sensation returns to normal in 4-6 weeks.

Avoid excessive/strenuous activity or athletics. These can cause swelling and/or bleeding. Begin again at 4-6 weeks.

The final result may not be apparent for at least one year.

Surface irregularities such as waviness or dents may result, particularly if they were present prior to surgery.

You must not be left alone for the first 24 hours following surgery, and you must not get up without assistance.

Do not hesitate to call our office, **(941) 923-1736**, if you should have any questions about your surgery. If it is necessary for you to contact the Doctor after 5 p.m. when the office is closed or on a weekend, please call the office number or Dr. Sessa's cell phone @ **(941) 586-8983.**

_____ _____

Patients Signature **Date**

_____ _____

Witness Signature **Date**

Lipotherme

How to care for treated areas after Lipotherme operation.

1. **Activities**
   * Have patient rest for at least 2 hours right after operation.
   * Place head above the level of the heart during sleep for 4 days after Lipotherme operation.
   * It is recommended to do a light exercise for 3-4 days after operation. This helps accelerate drainage of remaining lipolized fat inside the body.
   * Heavy exercise which increases body temperature and heart beat should be avoided for 2-3 weeks after operation.

2. **Wound healing & drainage**
   * Elastic bandages or compression garments are NOT routinely needed after Lipotherme operation since Lipotherme has great skin lifting effect by itself.
   * It is normal that light bloody liquid drains out of the incision site for 1-2 days. This liquid is mostly a combination of serum and anesthetic solution. Though it looks like blood, it only contains a small amount of blood.
   * Sufficient cooling with cold pack for 20 minutes immediately after operation is recommended in order to quickly reduce swelling.
   * Strictly avoid vigorous massage on the treated area.

3. **Pain**
   * Patient may feel muscular-pain-like discomfort starting from 2nd day post operation. In general, patients rarely observe bruising after Lipotherme operation, and even if patient observes bruising, it normally disappears within 1-2 weeks.

4. **Wash**
   * Patient may take a shower the day after operation.
   * Try to avoid swimming, sauna, and suntan for at least 2 weeks after operation.

RISKS AND HAZARDS

I understand that my informed consent requires that I know the risks and hazards, however rare and uncommon, related to the performance of these procedures. These risks include:

Medication/Anesthesia: Unfavorable reactions to prescribed medications, including the local anesthesia, may include allergic reactions with skin rash and itching, nausea, vomiting, convulsions, coma, respiratory failure, heart failure or even death.

Edema (Swelling): This occurs to some degree in after every surgical procedure and may last a number of days. Physician will give me special instructions to treat my edema, if necessary.

Bleeding: This is controlled during the procedure by electro-coagulation or pressure dressings. Some rare types of hematoma (blood clots) must be removed. Dressings may show blood spotting. If bleeding is sustained and continuous when I return home after the procedure, firm pressure over the area for 20 minutes will generally suffice. If sustained and continuous bleeding continues, I should maintain firm pressure directly on the area and phone the Physician. If I cannot reach the Physician, I should go to the nearest hospital Emergency Room immediately. In very rare cases, extensive bleeding or other complications could require hospitalization and blood transfusion.

Infection: This is rare and treated with antibiotics or may require surgical drainage.

Numbness: In cutting the skin, small nerve endings are also cut, which can result in numbness around or adjacent to the surgical area. As the small nerve endings re-grow, sensation usually returns in a matter of months, but in some rare cases, some numbness becomes permanent. If the procedure is performed on the face, there is a possibility of facial nerve paralysis (permanent numbness of the face), though it is extremely rare.

Uneven Results: With any form of liposuction, results can be uneven. I understand that this is less likely with Laser Lipolysis than with other liposuction procedures. I also understand there may be an additional charge to even out the results of the procedure.

Scarring: A scar develops when the skin is cut. The scar can sometimes become thick or hyper- or hypo-pigmented (darker or whiter) due to genetic factors, malnutrition, local micro trauma, stress, or an unhealthy lifestyle such as smoking or drinking. After a few months of healing, Physician may be able to repair or minimize particularly bad scars or unfavorable results. Again, there may be an additional charge for these services. I have no known history of thickened (hypertrophy or keloid) scarring, but it may occur if I am prone to its development.

Necrosis of the Skin: Necrosis occurs when a portion of skin dies and may appear as a dark scab at the incision site usually because of surgery trauma. Necrosis can be aggravated by high risk factors such as chronic diseases (like hepatitis, HIV, diabetes, etc.), previous surgeries in the proximity, malnutrition, or an unhealthy lifestyle (like smoking, drinking, etc.). Successive minor surgeries may shorten this healing process and obtain the best result. There may be an additional charge for these subsequent services.

Delayed Healing. Occasionally, during the healing process, an incision can re-open. Physician will discuss various methods of treatment. If I require additional surgery, there will be an additional charge.

MEDICAL HISTORY

I have made Physician and his staff aware of my medical history, including but not limited to any diabetes, heart trouble, lung or liver problems, kidney dysfunction, serious accidents, injuries, problems with pregnancy, high blood pressure, or bleeding problems.

Allergies:_____

Medications:_____