DR. P. SOLOMON
INFORMED CONSENT FOR COSMETIC SURGERY

NAME_____ DATE_____

1) I hereby request and authorize Dr. Philip Solomon, aided by any assistant he may require, to perform:

   _____

   _____

   _____

2) Dr. Solomon has fully explained in terms clear to me, the effect and nature of the operation(s) to be performed, the foreseeable risks involved, alternative methods of treatment, as well as what I can expect to experience if recovery is eventful. Unusual, but possible complications include but are not limited to:
   - sensory or motor nerve injuries or deliberate interruption of function (numbness or muscle weakness)
   - bleeding
   - infection
   - scarring
   - suboptimal aesthetic outcome
   - functional problems relating to nasal function (applicable to nasal surgery)

Initial _____

3) I also authorize the operating surgeon to perform any other procedures which he may deem necessary or desirable in attempting to achieve the object of the operation(s) or the elimination of unhealthy or unforeseen condition that he may encounter during the operation(s).

Initial _____

4) I consent to the administration of anaesthetics to be applied by or under the direction of Dr. Solomon and to the use of such anaesthetics and medications as he may deem advisable in my case.

Initial _____

5) If my operation is carried out under general anaesthesia, or with deep sedation, it is my understanding that the anaesthetic will be administered by a fully qualified Anaesthesiologist. He/She is a specialist certified by the Royal College of Physicians and Surgeons of Canada, and will take responsibility for the safe conduct of the anaesthetic administration. In particular, I was made aware that the main goal of the anaesthesia is the safe conduct of the surgery and the patients' comfort without risking serious complications related to the general health. The anaesthesiologist or the surgeon may be unable to prevent minor side effects such as bruising at the intravenous site or small damage to the dentition.

Initial _____

6) I acknowledge that no guarantee has been given to me as to the painlessness of the procedure or the length of the recovery.

Initial _____

7) I have been advised that the object of the operation(s) I have requested is improvement in appearance, NOT PERFECTION, and that there is the possibility that imperfections might occur, and

that the result might not live up to my expectations or the goals that have been established. In this connection, I know that the practice of medicine and surgery is not an exact science, and therefore, reputable physicians cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the operation(s) that I have herein requested and authorized.

Initial _____

8) I acknowledge that Dr. Solomon cannot and will not be responsible for any losses I may incur because of my absence from work or other occupation related to the treatment and care he will be providing. I have been informed that the period of time needed for recovery cannot be precisely estimated. A secondary, usually minor operation may at times be necessary to obtain the best possible result. The place and time, if such an operation becomes indicated ,will be determined by Dr. Solomon.

Initial _____

9) I have been advised that part of this surgery may be performed through external incisions in the skin that will leave permanent scars, the extent and locations have been described to me. I have been advised that scars take upwards of one year to mature, and the changes that normally occur in their appearance during the healing period have been described to me. On occasion, a thickening or spreading of the scar or thinning out of hair in some areas may develop whenever scalp incisions are necessary. This may require further treatment. I have been warned by Dr. Solomon that cigarette smoking increases the unpredictability of healing and scar formation.

Initial _____

10) I have been told that a medical-grade synthetic material may be used in the above mentioned operation(s) and have been advised of the risks, as well as the alternative methods of treatment.

Initial _____

11) I have been informed that the above operation(s) may require transplantation of _____from other areas of my body.

Initial _____;

12a) I understand that Dr. Solomon reserves the right to enhance his medical records with photography/videography of my surgical procedure. This is mandatory for all his surgical patients and complete confidentially will be maintained. Dr. Solomon will not perform surgery on patients who are not comfortable with the use of intra-operative photography/videography. These photographs/videos will remain his property for an indefinite period of time and will not be published without consent. All images will be stored electronically and will be backed up on cloud technology that requires password access.

12b) I authorize Dr. Solomon to use such photographs/videos specifically for internet advertising or marketing purposes such as social media or website galleries. These photographs/videos may also be used for academic purposes such as teaching presentations, publications, both print and on-line copy. Additionally, these images may be used in office for the purpose of patient education where other patients may benefit from their use.

Initial _____

13) I understand that if Dr. Solomon judges at any time that surgery should be postponed or cancelled for health reasons, he may do so.

Initial _____

14) Cancellation of surgery will cause expenses incurred from wasted operation time and non-utilized assigned medical staff. I agree to forfeit _____ deposit, should I cancel my surgery.

Initial _____

15) The fees for the surgery are for Dr. Solomon's time and effort. Dr. Solomon will make every effort to achieve the desired outcome. Cosmetic Surgery is not **100%** predictable and neither are the outcomes. For this reason refunds will not be provided.

Initial_____

16) IF THE PATIENT REQUESTS A REVISION PROCEDURE FOR COSMETIC PURPOSES, A NOMINAL FEE OF $1000 WILL ENSUE TO COVER THE COSTS OF STAFFING, ANESTHESIA AND HOSPTIAL FEES. THE PRIMARY SURGERY PAYMENT WILL NOT COVER THIS SECONDARY PROCEDURE UNDER ANY CIRCUMSTANCES.

Initial _____

17) If patient requests a revision procedure following their minor surgical procedure performed under local anaesthesia at our clinic, a fee of $500 will apply.

Initial _____

18) In some cases following rhinoplasty, dermal filler may be desired to smooth slight imperfections. There is a fee of $350 + HST, for this procedure.

Initial_____

19) I agree to follow the instructions given to me by Dr. Solomon to the best of my ability before, during and after the above-named surgical procedure(s).

Initial _____

20) I hereby state that the information provided by myself to Dr. Solomon during my diagnostic evaluation is correct.

Initial _____

21) I understand that the nature of my operation(s) allows it to be carried out on an outpatient basis, and I will be discharged home as indicated on the information sheet or no later than early morning of the next day. Should unusual circumstances necessitate longer observations and hospitalization, I will accept a transfer to a local hospital. I understand that in such event I will continue to be under the care of Dr. Solomon who may request opinions of other specialists if needed. Costs of such hospitalization and other specialist's care, if necessary, will be covered by my provincial insurance plan. If such coverage is not available, I will accept financial responsibility for the treatments and hospitalization.

Initial _____

22) I hereby agree that the relationship between Dr. Solomon and myself shall be governed by and construed in accordance with the laws of the Province of Ontario.

Initial _____

23) As to my knowledge I am not pregnant. If I suspect that I may be pregnant, I agree to undergo a pregnancy test with my family doctor prior to said surgery.

Initial _____

24) I acknowledge that the treatment/service will have been performed in the Province of Ontario and that the Courts of the Province of Ontario shall have jurisdiction to entertain any complaints, demands, claims or cause of actions, whether based on alleged breach of contract or alleged negligence arising out of the treatment. I hereby agree that I will commence any such legal proceedings in the Province of Ontario and only in the Province of Ontario and hereby submit to the jurisdictions of the Courts of the Province of Ontario.

Initial _____

26) I agree to the sharing and sending of electronic records including photography to physicians and institutions involved in your care of care, including the anesthesiologist, by email or fax.

Initial_____

27) If required, I agree to an in person consultation with the anesthesiologist prior to surgery.

Initial_____

28) If receiving general anesthetic, I agree that I must arrange for a family member or friend to drive me home following my surgical procedure. I must also have a family member or friend stay overnight in my home the first night.

Initial_____

29) I acknowledge and agree that I am responsible for scheduling my follow-up appointments with Dr. Solomon.

Initial_____

30) Lastly, I acknowledge that I have been given the opportunity to ask questions if desired regarding matters covered in the preceding consent, and that these questions have been answered to my satisfaction by either Dr. Solomon, his nurse or his staff.

Initial _____

DATE: _____ SIGNED: _____

(Patient or person authorized to given consent for the patient)

WITNESS: _____ SIGNED: _____

(Patient's Guardian, if a minor)

_____

DR. PHILIP SOLOMON

Updated: NOVEMBER, 2019