



INFORMED CONSENT FOR COSMETIC PROCEDURES

Name of patient _____ Date: _____

I hereby requests and authorize Dr. Beals, aided by an assistants he may require to perform _____ for the purpose of attempting to improve _____.

Dr. Beals has fully explained, in terms clear to me, the effects and nature of the procedure(s) to be performed, alternative methods of treatment and possible risk factors to include objectionable scar, infection, pain, tingling, numbness, hyperpigmentation and hypopigmentation. Lastly, I have been given the opportunity to ask any questions regarding the matters covered in the preceding two sentences, and these questions have been answered to my satisfaction. I also authorize Dr. Beals to perform any other procedure which he may deem necessary or desirable in attempting to improve the condition stated in paragraph one or to treat any unforeseen condition or complications that he may encounter during the procedure.

I have been advised that the goal of the procedure I have requested is improvement in the appearance, not perfection, that there is a possibility that imperfections might ensue, and that the results might not meet my expectations or the goals that have been established. In relation to this I know that the practice of medicine and surgery is not an exact science and that, therefore, no guarantee or assurance has been made by anyone regarding the procedure which I have herein requested and authorized.

I understand that if Dr. Beals judges at any time that my procedure should be post-poned or canceled for any reason, he may do so.

I hereby state that the information furnished to Dr. Beals during my diagnostic evaluation is correct.

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

Signature: _____ Date: _____

Physician: _____ Date: _____