Anna C. Pavlides, M.D., F.A.C.O.G.
Michael A. Benson, M.D., F.A.C.O.G.
Rita Shats, M.D., F.A.C.O.G.
Catherine S. Meleka, MD
Lynda Surck, PA-C
Coleen K. Abrams, PA-C

FEMILIFT TREATMENT CONSENT FORM

DATE ____/____/____

CORPORATE COMMONS TWO, 2 TELEPORT DRIVE, Suite 207 • STATEN ISLAND, NY 10311 Tel: 718.273.5500 Fax: 718.273.3232

I, _____ , hereby authorize Dr. _____ and/or his/her associate(s) to perform a Femi*Lift* procedure.

The purpose of this treatment/procedure was fully explained to me. I was informed of expected benefits and complications, attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment including no treatment. **I** acknowledge that no guarantees or assurances have been made to me concerning the results intended from the medical treatment, operation or procedure. I have been given an opportunity to ask questions, and all my questions have been answered fully and to my satisfaction.

I understand that during the course of the operation or procedure unforeseen conditions may arise which necessitate surgical or other procedures different from those contemplated. I therefore consent to the performance of additional operations and procedures which the above-named physician or his/her associates or assistants may consider necessary.

I further consent to the administration of such anesthetics as may be considered necessary or advisable by the person authorized to administer anesthesia. I recognize that there are always risks to life and health associated with anesthesia, including sore throat, nausea and vomiting, and/or more serious but rare risks such as drug reactions, cardiac arrest, paralysis and death, and such risks have been fully explained to me.

I CONFIRM THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE.

Patient/Guardian: _____ _____
signature *print name*

Interpreter (If required): _____ _____
signature *print name*

Witness: I attest to the fact that the signature is that of the Patient/Guardian

_____ Date ____/____/____ Time _____:_____ AM PM
signature of witness

I hereby certify that I have fully explained the medical treatment/operation/procedure noted above, including the possible benefits, complications and risks that may arise and the alternatives to the proposed procedures/operations/course of treatment. I have offered to answer any questions and have fully answered all questions raised. I believe that the patient/guardian fully understands what I have explained and answered.

Physician: _____ Date ____/____/____ Time _____:_____ AM PM