CONSENT FOR HAIR TRANSPLANTATION PROCEDURE

1. I, ____________________________________ hereby give consent to Dr.Michael F. Wisiorek, D.O., Director of Hair Restoration & Aesthetics of Buffalo and his hair transplantation team to have hair replacement surgery performed upon me. I also consent to any other medical services during the procedure that may become medically reasonable and necessary. This includes, but is not limited to, the administration of anesthetics and/or sedatives necessary to perform a hair transplant or eyebrow restoration procedure.

2. I am aware that good results will depend in part upon my completing the necessary number of operations and density recommended by the surgeon. However, because many variables exist, I have not been promised or guaranteed good results. I also understand that the quality and amount of preexisting hair are major factors in the ultimate result, which varies from one person to another. I understand I will not have hair of the same thickness/density as I had prior to the onset of my hair loss.

3. Prior to my consenting to hair transplant surgery, I state that I have read or have been given the opportunity to review literature available to me that may include:

Review of websites
List of possible complications
Pre-operative instructions
A fee schedule of current charges

4. I fully understand the results that I may reasonably expect. I understand that hair transplants are not perfect. An explanation of this procedure has been given to me. I have had the opportunity to ask any questions regarding this procedure. I do understand that I will not obtain a full head of hair from the procedure. I understand that visibility of the sites following a transplant surgery can last for a number of days.

5. The pros, cons, and alternatives to hair transplantation have been explained. I have the option of doing nothing, wearing a hairpiece/wig, using prescription medication or having a transplant surgery or other type of scalp surgery procedure. A combination of the above is also possible. I have been informed of all options available.

6. I understand that more operations may be recommended later due to ongoing loss of my non-transplanted hair. I understand that all recommendations made during my consultation and treatment are estimates and may change later. __ _______ . **(Initial)** If the doctors or I feel an additional procedure is necessary, I understand that there will be additional surgical fees.

7. I understand that every time an incision is made in the human body, a scar will occur, although every effort will be made to make the scar inconspicuous. Superficial crusting, pinkness, or redness of the incision area may occur, but those will likely be temporary. A thickened or raised scar (a hypertrophy scar/Keloid) is

possible. This is more likely to occur in patients with a history of this type of scarring. Wide scarring is also possible in the donor area.

8. I have been informed that hair transplantation is generally a safe procedure; however I am aware that complications may occur. The more common complications and a partial list of rare complications of this surgery have been explained to me and/or I have reviewed a list of them. Unforeseen, rare complications, such as unanticipated reaction to medications and anesthetics, uncommon infections, and unusual healing responses, are possible. Every unforeseen complication may not have been discussed with me in detail, but I do understand that such risks do exist.

9. I give consent for disposal of any debris.

10. I believe 1 have been well informed. I understand that good results are expected, but the practices of medicine and surgery are not exact sciences. I understand that knowledgeable practitioners sometimes disagree as to the best methods of treatment to achieve desired results.

11. I give consent for Dr. Wisiorek and his assistants to take and exhibit before, during, and after, photographs and/or videos of me for purpose of education.

12. It has been explained to me that the amount and location of future hair loss on the scalp, including the sides and back area cannot be predicted. I do understand that it is possible to lose my existing hair at any point in the future. I do understand that this may affect the appearance of the grafted area.

13. There is a possibility of some temporary hair loss in the back of the scalp surrounding the area where the donor strip was removed. In rare cases, there may be permanent loss of hair adjacent to the surgical incision. In the transplanted area shedding of existing hair, called surgical effluvium, may occur after the surgery. If this hair is at the end of its normal life span, it may not return.

14. I understand that the success of the hair transplant procedure is dependent upon my closely following all instructions. This includes, but is not limited to, pre-operative and post-operative activities and precautions, which have been explained to me. I have also received a written copy of these instructions.

15. This consent was read and signed while I was not under the influence of medications that might alter my mental capacity to understand its contents.

16. I certify this form has been read or it has been read to me, the blank spaces have been filled in, and I understand its contents.

17. I have disclosed all information regarding past and present medical conditions, current medications, and known drug allergies. This information is necessary so that the proper medical treatment is given at all times during the transplant procedure.

Some post-operative discomfort may be experienced.__________ **(Initial)**
This procedure is offered to obtain the best results for the patient, separate of any profit motive.

I acknowledge that I am responsible for payment of these services with no fee reimbursement regardless of procedure results. I understand that the fee paid is for the procedure and not for an expected result.

Cost: $ _______________

____
Patient's Signature Date

____
Witness Date

____
Doctor's Signature Date