IHTI SURGICAL DISCLOSURE AND CONSENT FORM

THIS DOCUMENT CONTAINS IMPORTANT DISCLOSURES, AGREEMENTS AND INFORMATION ABOUT THE HAIR TRANSPLANT OR HAIR RESTORATION SURGICAL PROCEDURES YOU HAVE ELECTED. PLEASE REVIEW THESE MATERIALS CAREFULLY AND BE SURE TO ASK ANY AND ALL QUESTIONS YOU MAY HAVE BEFORE THE SURGERY BEGINS.

I,____, hereby provide my consent for International Hair Transplant Institute, its physicians, assistants, staff and employees (hereinafter "IHTI") to perform the surgical procedures I have selected for hair transplantation and restoration, including the administration of anesthetics and sedatives, by oral, intramuscular, inhalation or intravenous routes. The procedures have been explained to my satisfaction, and I fully understand the nature, risks and consequences of the procedure and accept same.

I understand that this procedure is cosmetic in nature and that I have the option of doing nothing at all, wearing a hairpiece, using medications, or having other forms of surgical and non-surgical treatment to address my concerns.

I understand that IHTI makes every effort to incorporate the most current techniques and technology into its hair transplant procedures. Total stereo-microscopic dissection is used in all procedures, as well as single-strip harvesting techniques. In addition, automated implanting devices may be used for all or part of the procedure.

I understand that my elected procedure involves the collective and specialized skill, knowledge and experience of IHTI physicians, surgical assistants, staff and other employees. In electing to proceed with this surgery, I have personally consulted with John P. Cole, M.D., and am therefore not relying on any single or particular statement provided by any non-physician employee, agent, representative or former patient of IHTI as a basis of electing to proceed with my recommended medical treatment and surgical procedure.

BODY HAIR TRANSPLANTATIONS: If I am having body hair transplantation, I understand that growth cannot be guaranteed. I realize that body hair grows at a much slower rate than scalp hair and may never fully grow in the manner I desire. I may also only achieve a maximum of 40-70% growth total from the body hair transplantation. I acknowledge that body hair transplantation is still considered to be in the experimental stages and I agree to assume all risks involved the transplantation of body hair. .

SCAR REVISIONS: If I am having a scar revision/repair/reduction, I recognize that the grafts transplanted into the scar and surrounding tissue may not grow. I understand that scarred tissue may not accept the grafts, I accept that risk and wish to proceed with the surgery. I understand that if I am having a scar reduction, that there is a likelihood that the scar may widen over time.

PLUG REDISTRIBUTIONS: I understand that removing and redistributing grafts takes an extremely long time, may require multiple procedures, and that the number of grafts redistributed per session as well as the growth rate of those grafts are in no way guaranteed. I accept the risk that the grafts may not grow at all and that there is no guarantee that all scarring or damage can be fully repaired.

I understand and agree that there are risks involved in any surgical procedure or treatment and that it is not possible to guarantee a successful result or to assure an outcome that will meet my goals, expectations or satisfaction. I recognize that I have been given every opportunity to ask questions and I have elected to go forward with the surgery despite the complications and/or risks. I clearly understand and agree with the surgical procedure I have elected and I realize there are known and unknown risks and complications, including but not limited to the following:

- **SCARRING**: Every time an incision is made in the human body, a scar will occur, even though every effort has made to make the scar as inconspicuous as possible. A STRIP HARVEST may produce superficial crusting, pinkness, or redness of the incision area, which may be temporary or permanent. Some area of skin around the suture edges may be lost and this may cause deep crusting. A stretched, widened scar is possible, as is a

thickened or raised scar (hypertrophic/keloid). Significant scarring may also occur in people who are predisposed to scarring or who have had previous transplants.

- **ANESTHESIA REACTIONS**: Local anesthetics (lidocaine, bupivacaine) with Adrenaline (epinephrine) may have effects on many of the body's organ systems, including the heart. Such effects may include allergic reactions, irregular heartbeats, or heart attacks. Such risks are uncommon with surgical procedures performed under local anesthesia but can occur. Patients on the type of heart or blood pressure medications called "beta-blockers" may be particularly sensitive and may have a reaction.. If you are on any heart or blood pressure medication please list below.

I am currently taking____ I am not on any heart or blood pressure medication ______ **(Please initial)**

- **ALLERGIC REACTIONS**: I understand that there may be unusual, unexpected or allergic responses to drugs, medications or foods, prescribed or used before, during or after the surgical procedure I have elected. I recognize that it is important for the physician to be advised of any problem I, or any member of my family, have had with reactions to drugs and medications taken in the past six months, including over-the-counter and street drugs.

I am allergic to ____. I am not allergic to any drugs, medications or foods. ______ **(Please initial)**

In the last 6 months, I have taken____. In the last 6 months I have not taken any prescribed, over-the-counter or street drugs. ______ **(Please initial).**

- **FOLLICULITIS**: Folliculitis is condition in which hair follicles become infected with bacteria (most commonly staph infection). Folliculitis usually appears in the post-operative period. The associated symptoms include redness around the grafts, pustules around emerging hairs, and itching. There may be some associated loss of hair in the involved folliclesThe treatment for folliculitis consists of administration of antibiotics that may be given for an extended period of time.

- **HAIR LOSS**: If having a STRIP HARVEST or Follicular Unit Harvest, there may be hair loss in the back of the scalp in the area surrounding the removed strip of hair. This hair will generally grow back. There may be permanent loss of hair in the skin adjacent to the surgical incision. In the transplanted area, you may experience shedding of your existing hair (shock loss) following the surgery (a process called telogen effluvium). If this hair is at or near the end of its normal life span (miniaturized hair), it may not return. Because genetic balding is a continuous process, you may continue to lose more hair over time. If this occurs, a subsequent hair transplant procedure may be necessary.

- **HAIR TEXTURE CHANGES**: When new hair begins to grow it may be different than your natural hair. Over time the hair generally resumes its normal character but it is possible that these hair texture changes may persist.

- **FAILURE OF TRANSPLANTED HAIR TO GROW**: As in all surgical procedures results cannot be guaranteed. It is possible that some or all of the transplanted hair may fail to grow. Every effort will be made to give you the maximum yield from your transplanted hair.

- **NUMBNESS**: Numbness of the scalp may occur due to cutting of fine nerve fibers in the skin. While this is expected to gradually disappear over several months, it is possible that all of the sensations may not return and that numbness will become permanent.

- **SUN DAMAGED SKIN**: After your transplant, you must still protect your scalp from the damaging rays of the sun. New hair makes close observation of your scalp important because unusual new skin growths, or skin changes, may be more difficult to see. In addition, if you have a history of skin cancer or sun damaged skin, you should be followed by your dermatologist. Sun damaged skin may hinder hair growth.

- **INFECTION**: Infection after hair transplantation can occur. The symptoms of infection include swelling, redness, tenderness or puss at the surgical site and may be associated with fever or chills. If you experience any of these symptoms, contact us at once. If you cannot reach us contact your primary care physician or go to the Emergency Room. Any infection can be serious. If infection occurs, seek medical treatment immediately.

- **OTHER**: There may be temporary swelling, discoloration, or bruising associated with the procedure. There may be the formation of a cyst at a graft site, ingrown or buried hairs, hematoma (localized blood clot), or rejection of a graft. In areas of scar tissue, grafts may grow poorly or not at all.

For patients who have had prior hair restoration surgery at another facility:

_____ I acknowledge that prior to contacting IHTI, I received Hair Transplants/Scalp Reductions from another physician and the results of these procedures were below my expectations**. (Please initial)**

_____ I further acknowledge that IHTI bears no responsibility for my present condition. I also acknowledge that I have been informed that IHTI may not be able to correct my condition, although they will attempt to do so. **(Please initial)**

Consent for an in-house review of my medical record:

_____ In the ongoing pursuit of quality patient care, IHTI selects a number of patient medical records for periodic review. I hereby give my consent for IHTI or its agents to review my medical record should it be selected. This consent shall be valid until revoked in writing. I understand that the information contained in my medical record will be kept strictly confidential at all times. **(Please initial)**

Photography:

_____ Routine full face and scalp photographs will be taken for my office file. I consent to the taking of these photographs that may be used for in-house medical, educational, or scientific purposes without my further agreement providing that my name is not revealed on the pictures or in the accompanying text. This consent does not include the use of any photographs for advertising purposes or out-of-house without my specific consent for such use. **(Please initial)**

Consent:

_____ I have had the opportunity, in advance of my procedure, to fully read and understand the contents of material given to me by IHTI including" The Patient's Guide to Hair Restoration", my consultation letter, this surgical disclosure consent form and pre-operative instructions. **(Please initial)**

_____I have been given the opportunity to talk to patients at IHTI, consults or through contacting IHTI's reference and referral list in order to understand the type of results that I might be able to achieve and to allow me to more fully appreciate the type of results that I am likely to get. The consults and list of references and referrals have been made available to me so that I could explore the hair transplant experience with others who have already gone through it. **(Please initial)**

_____ I am aware that the practice of medicine and surgery is not an exact science and that knowledgeable practitioners sometimes disagree as to the best methods of treatment to achieve desired results. I certify that no one has made any guarantee or warranty as to the final outcome or appearance that may be expected. **(Please initial)**

_____ The procedure, its indications, risks and alternatives have been explained to me by IHTI and through the inquiry package, and the pre-operative instructions. I recognize that during surgery unforeseen conditions can occur that may alter the course of surgery and necessitate deviating from the original plan. This may include the transplantation of more or fewer grafts than scheduled. I hereby authorize and request IHTI to use its professional judgment to complete the surgery in a manner that will facilitate the best results in the safest way possible. I have read and understand this disclosure and consent for surgery. I have been given the opportunity to ask questions, and all of my questions have been answered to my full satisfaction. **(Please initial)**

_____ This consent was read and signed by me while I was not under the influence of medications or other substances that can cause drowsiness or impair judgment. **(Please initial)**

______This Agreement is being made under and will be interpreted in accordance with the laws of the State of Georgia. The exclusive jurisdiction and venue for any action to interpret or enforce the terms of this consent and disclosure form shall be in an appropriate State or Federal Court sitting in Fulton County Georgia and each party hereto consents to such exclusive jurisdiction and venue. **(Please initial)**

Consent to Procedure(s) and Treatment: Having read this form and talked with the physician, my signature below acknowledges that: I understand and voluntarily give my authorization and consent to the performance and agreement of the procedure(s) I have chosen.

______________________________	______________________________
Signature of Patient	Date
______________________________	______________________________
Signature of Physician	Date
______________________________	______________________________
Witness for IHTI	Date