dr**griffiths**

www.drgriffiths.es email: info@drgriffiths.es Tel: 91 101 2177

Name:

Address:

DNI:/ Passport Number:

Informed Consent For Hair Transplant Surgery

1. I request and authorise **Dr. Peter Griffiths** to further diagnose or treat the conditions(s) which appear indicated as follows: Hair Loss or Male Pattern Baldness / Eyebrow alopecia.

2. The procedures deemed necessary to diagnose or treat my condition has been explained to me by my doctor and I understand the nature of the procedures summarised below and authorise the performance of such procedures: FUE hair transplant or BHT (body hair). Please circle relevant surgical technique to be used).

3. I understand medical and surgical procedures require the cooperation and services of doctors, nurses, technicians, assistants, and other personnel and I request and authorise such personnel to undertake this service and care.

4. I have been advised that during the procedure the doctor may deem it necessary to alter the procedure due to medical, health or "result" related reasons. If I need anything additional during the procedure, I permit the doctors to proceed.

5. I have been informed and understand there are certain risks and consequences associated with the procedure described in item 2. The risks may include: Infection, bleeding, post-operative pain, unsatisfactory scars, keloid formation, necrosis, hematoma, hair loss/shock loss temporary or permanent.

I also consent to the administering of anaesthesia and other medications deemed necessary.

6. I consent and authorise the clinic with my knowledge to own, retain, preserve, or dispose of any tissues or specimens which are removed from my body including use in research which may result in commercial applications.

PATIENT SIGNATURE

7. I agree with the hair line design and position my doctor has made and I agree hair line design is a gradient of finer density to thicker hair density and not an immediate thick wall of hair.

8. I consent to the photography, filming, recording or televising of the procedure to be performed, including appropriate portions of my body for medical, scientific research, educational or commercial purposes, provided my identity is not revealed by the picture or by the texts accompanying them.

9. The alternative forms of diagnosis or treatment have been explained to me.

10. This consent covers this surgery and all subsequent surgeries required to complete my hair restoration.

I understand the practice of medicine or surgery is not an exact science and acknowledge that no guarantees or promises have been or can be made to me concerning the specific results of the procedure being performed. All due care and attention will be taken to ensure medically and cosmetically the optimum result, but I understand that there are risks involved in any surgical procedure and that it is not possible to assure an outcome that will meet my goals or guarantee my happiness.

In the event of dissatisfaction or dispute regarding the service provided, I agree to resolve the matter via the Mediation Service of the Madrid College of Lawyers (Centro de Mediacion del Ilustre Colegio de Abogados de Madrid).

I recognise that I have been given every opportunity to ask questions and I have personally made the decision to go forward with the surgery procedure.

Date:

PATIENT SIGNATURE:

DOCTOR'S SIGNATURE: