



Units Agreement

The determination of how many Follicular Units are to be transplanted during your procedure is based upon the information discussed during your consultation and subsequently referenced to in your consultation letter. This information includes your approximate donor density, scalp laxity (looseness) and the personalized plan relating to your goals and objectives. Based on this information, you understand that:

(i) your exact donor density and scalp laxity cannot be determined until the procedure has begun, and (ii) although you and the physician agree on the specific number of Follicular Units to be transplanted in accordance with the physician's best medical judgement, it may not be possible to achieve the exact number of Follicular Units scheduled. The physician will make every reasonable effort to achieve the number of grafts scheduled.

HOWEVER, should the physician determine at the time of surgery that he is able to harvest additional Follicular Units than originally agreed to, prior to preoperative sedation; you may request the physician to harvest and transplant such additional Follicular Units by signing where indicated on this Agreement.

I fully understand the above and request the physician to harvest additional follicular units as, in the physician's judgment, is medically safe to do so.

I hereby select one (f) of the following options:

- A. YES, I request the physician to transplant as many additional Follicular Units as safely possible which are appropriate to the recipient site.
- B. YES, I request the physician to transplant additional Follicular Units if **safe and appropriate**. I wish to limit the number of additional Follicular Units to
- C. NO, I request the physician to remain as close as possible to the original number of Follicular Units scheduled for this procedure .

I agree to be responsible for the payment of the additional Follicular Units transplanted during my procedure. I will pay the same rate per Follicular Unit as indicated in my financial summary. I understand that payment is to be made on the same day of the procedure by personal check, credit card, travelers check, or cash, unless other financial arrangements have been made and agreed to in advance.

Patient's Signature:

Date:

GHO Witness:

Date:

METHOD OF PAYMENT:

Personal/Cashiers/Travelers Check:

Credit Card:

Cash:



Consent for Hair Transplantation Procedure

I, hereby grant permission for Peter Hajduk M.D., a physician of GHO, and his assistants, to perform a surgical procedure upon me for hair transplantation, including the administration of anesthetics and sedatives, by oral, intramuscular, inhalation or intravenous routes as may be necessary or desirable to do this procedure for the treatment of hair loss. The procedure has been thoroughly explained to me by the physician, and I fully understand the nature and consequences of the procedure.

I understand that the procedure of hair transplantation is cosmetic in nature and that I have the option of doing nothing at all, wearing a hairpiece, using medications, or having another form of hair, restoration surgery. These options have been discussed with me and have been fully explained in the numerous printed materials provided to me by GHO

I understand that GHO makes every effort to incorporate the most current techniques and technology into their 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 there are risks involved in any surgical procedure or treatment and that it is not possible to guarantee or to give assurance of a successful result or to assure an outcome that will meet my goals or guarantee my happiness. I recognize that I have been given every opportunity to ask questions and I have made the decision to go forward with the surgery. I clearly understand and agree to the planned surgical procedure. I have been told that hair transplantation is a generally safe procedure; however, I realize that the following are possible events or complications that may occur:

- **SCARRING:** Every time an incision is made in the human body, a scar will occur, although every effort will be made to make the scar as inconspicuous as possible. Superficial crusting, pinkness, or redness of the incision area may occur, but these effects are usually temporary. Rarely, some area of skin around the suture edges may be lost and this will cause deep crusting which will take longer to heal. A stretched, widened scar is possible, as is a thickened or raised scar (hypertrophic/keloid). Significant scarring is more likely to occur in people who have had a history of the above type of scarring or who have had previous transplants taken from the donor area.
- **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 even, in unusual circumstances, a heart attack. Such risks are uncommon with surgical procedures performed under local anesthesia. Patients on the type of heart or blood pressure medications called "beta-blockers" may be particularly sensitive to epinephrine. 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 during the surgical procedure. I recognize that it is important for the physician to be informed of any problem I, or any member of my family, have had with reactions to drugs and also the medications I have taken in the past six months, including over-the-counter drugs, especially aspirin and any street drugs.

I am allergic to.....

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

- **FOLLICULITIS:** Folliculitis is an uncommon problem in which hair follicles become infected with bacteria (most commonly staph). Folliculitis usually appears in the postoperative 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 follicles, but since the problem is localized to individual hair follicles, the loss is rarely significant from a cosmetic standpoint. The treatment consists of oral antibiotics that may be given for an extended period of time.
- **HAIR LOSS:** There may be temporary hair loss in the back of the scalp in the area surrounding the removed strip of hair. This hair will generally grow back. Less commonly, 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 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 desired.
- **HAIR TEXTURE CHANGES:** When your new hair begins to grow it may be more kinked or wavier than your original hair. Over time the hair generally resumes its normal character. 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 necessary cutting of fine nerve fibers in the skin. This is expected to gradually disappear over several months, but it is possible that all of the sensations may not return



- **SUN DAMAGED SKIN:** After your transplant, you must still protect your scalp from the damaging rays of the sun. Your 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. It is possible that significantly sun damaged skin may hinder hair growth.
- **INFECTION:** Although infection in hair transplantation is rare, an antibiotic will be given to reduce the possibility of infection. 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.
- **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 institution:

I acknowledge that prior to contacting GHO I received Hair Transplants/Scalp Reductions from another physician and the results of these procedures were below my expectations. I further acknowledge that GHO, its physicians and employees, bear no responsibility for my present condition. I also acknowledge that I have been informed that GHO physicians may not be able to correct my condition, although they will attempt to do so. (Please initial)

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

..... In the ongoing pursuit of quality patient care, GHO selects a number of patient medical records for periodic review. I hereby give my consent for GHO. Physicians to review my medical record should it be selected. I understand that the information contained in my medical record will be kept strictly confidential at all times.

Photography:

..... In addition to the routine full face and scalp photographs that will be taken for my office file, I consent to the taking of photographs that may be used for 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 without my specific consent for such use.

Additional photos may be taken (initial): with the full face and scalp exposed

Of the scalp and eyebrows up



Consent:

..... I have had the opportunity, in advance of my procedure, to read and understand the contents of material given to me by the GHO including: "the surgical consent form and preoperative instructions. **(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 my physician, and through the inquiry package, and the preoperative 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 the surgeon to use his/her professional judgment to complete the surgery in a manner that will produce the best results in the safest way possible. I have read and understand this consent for surgery. I have been given the opportunity, by my physician, to ask questions, and all of my questions have been answered to my full satisfaction. Any objections have been noted or stricken and initialed by me. **(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.

Patient's Signature:

Date:

GHO Witness:

Date:

I certify that on this date I have observed this patient carefully read and sign this consent form of his/her own free will.

Witness for GHO:

Date: