INFORMED CONSENT FOR CORRECTION OF GYNECOMASTIA

1. Bleeding or hematoma with need for surgical evacuation
2. Infection
3. Seroma with possible need for drainage
4. Dimpling or waviness in skin, asymmetrical contour
5. Temporary or permanent numbness of skin or nipple areolar complex
6. Chest asymmetry or nipple areolar complex asymmetry in size, shape, and position
7. Long-term induration (woodiness) and swelling
8. Permanent and noticeable scars
9. Skin burns if ultrasonic liposuction used
10. Skin redundancy and possible need for revision
11. Possible recurrence of gynecomastia after surgery
12. Use of nicotine (in any form) or smoking is detrimental and can lead to poor healing with skin necrosis and loss

The complications and limitations of the above-mentioned procedure have been explained to me in detail and in terms I can understand. I am aware that the possibility of unforeseen complications also exists. I have been given the opportunity to question each point listed and have been informed of alternative treatment options, including the option of no treatment.

I understand that any clinical photographs or x-rays taken of me are the property of the physician and may be used for medical education.

In the event that revisional or secondary procedures are required, I understand that I will be responsible for both facility and anesthesia fees.

I hereby request, authorize, and give my consent to Christopher J. Kovanda, M.D. to perform the above named procedure and or whatever other treatment he may deem advisable in the diagnosis and treatment of my case.

________________________________________  __________________________
Patient Signature                        Witness