INFORMED CONSENT

PATIENT NAME:_____ DOB:_____

1. I hereby request and authorize Dr._____ / or such physician to perform on me the following procedure(s):

Injection of cross-linked hyaluronic acid into the penis as a dermal filler, the nature of which has been explained to me, by my physician in the plain language that I completely understand.

2. My physician has explained that the above-named procedure is a generally safe and well-tolerated procedure. I also understand this is an off-label use of the aforementioned product. I understand that there are always certain risks and consequences that are associated with these procedures, including irregularities in the penis, bleeding, infection, loss of penile tissue or sensation, the need for revisions and possible filler removal. My physician has explained that the most common complications are listed above but do not exclude any other possible unforeseen complications. My physician has explained the risks, benefits and any medically and surgically acceptable alternatives. My physician has also discussed expectations of the recuperation process which are associated with the procedure(s).

3. I consent to the administration of medication(s) administered by or at the direction of the professional performing the above-mentioned procedure(s) for the purpose of reducing pain or discomfort and/or emotional stress I may experience. I have been informed and understand the risks, benefits and alternatives.

4. I also understand there are general risks in performing any surgical or invasive procedures including but not limited to, severe loss of blood, infection, allergic reaction, cardiac arrest, pain or death. I understand I have the right to refuse this procedure, I do hereby authorize and request whatever steps and whatever procedure(s) deemed advisable which may be in addition or different from those that are planned.

5. I consent to the appropriate disposal by the office of any tissue and other bodily materials which may be removed during the course of the procedure(s).

6. I have been made aware that no guarantees or assurances have been made to me as to any of the results and risks.

7. I consent to the observation of my procedure by other health care providers for educational purposes. I further consent to the admittance of qualified observers and/or technical advisors as determined by my physician.

8. I further consent to my physician (or designee), making a photographic, videotape or similar records of the procedure(s), which shall remain in my physician's custody for the purposes my physician has explained, and I have agreed to.

9. I am satisfied with the explanation I have received from my physician. I have asked any additional questions to satisfy my concerns. I do not have any further questions regarding the planned procedure(s) stated above.

I HAVE READ THE ABOVE PARAGRAPHS AND THEY HAVE BEEN EXPLAINED TO MY SATISFACTION.

_____ _____

Patient Signature, (guardian/surrogate if patient unable to sign) **Witness (to signature only)**

_____ _____

Date **Reason for guardian/surrogate signature**

PHYSICIAN CERTIFICATION:

I, Dr._____, hereby certify that the patient, guardian or surrogate (1) has been fully informed by me or one of my physician associates, in layman terms understandable to the patient, of the nature of the procedure, the alternatives as to treatment, possible results or non-treatment, expectations of the procedure including recuperation process and the benefits of and risks to the patient, inherent or associated with the procedure and when the use of anesthetics (sedative) agents are administered by or at my direction (2) has authorized the performance of the procedure and when appropriate, the anesthetic (sedative) agent.

_____ _____

Date

Signature of Dr. _____