

INFORMED CONSENT FOR AESTHETIC VAGINAL SURGERY

THIS IS A LEGAL DOCUMENT. PLEASE READ CAREFULLY BEFORE ADDING INITIALS & SIGNATURE IN HIGHLIGHTED AREAS.

This document outlines the potential risks, benefits, alternatives, and financial considerations related to your upcoming aesthetic vulvovaginal surgery. It is intended to ensure that you are fully informed and understand all aspects of the procedure. Your initials and signature confirm that you have read, understood, and voluntarily consent to the procedure.

I, _____, HEREBY AUTHORIZE AND CONSENT TO DR. PATRICK NOSTI AND HIS DESIGNATED MEDICAL STAFF TO PERFORM THE PROCEDURE(S) LISTED BELOW			
PRIMARY SURGERY		REVISION	
I have chosen the following location for my surgery:			
<input type="checkbox"/> Office Procedure Room <input type="checkbox"/> Surgery Center			
<input type="checkbox"/> Labia Minoraplasty <input type="checkbox"/> Hybrid <input type="checkbox"/> Barbie Appearance <input type="checkbox"/> Rim Appearance <input type="checkbox"/> No preference	<input type="checkbox"/> Curvilinear	<input type="checkbox"/> Wedge	<input type="checkbox"/> Labia Minora Revision
<input type="checkbox"/> Labia Majoraplasty			<input type="checkbox"/> Labia Majora Revision
<input type="checkbox"/> Clitoral Hood Reduction <input type="checkbox"/> Lateral <input type="checkbox"/> Vertical			<input type="checkbox"/> Clitoral Hood Reduction Revision
<input type="checkbox"/> Perineorrhaphy/Perineoplasty			<input type="checkbox"/> Perineorrhaphy/Perineoplasty Revision
<input type="checkbox"/> External Hemorrhoidectomy or Anal Tag Removal			<input type="checkbox"/> External Hemorrhoidectomy or Anal Tag Revision
<input type="checkbox"/> Skin Resurfacing	<input type="checkbox"/> AREA: _____		
<input type="checkbox"/> Resuturing	<input type="checkbox"/> AREA: _____		
<input type="checkbox"/> Hymenoplasty			
<input type="checkbox"/> Vampire Wing Lift®			
<input type="checkbox"/> O-Shot®			
<input type="checkbox"/> Other:			

(initial) Risks and Healing Expectations

- I understand that I may not drive or travel alone after receiving sedating medications and must arrange a responsible adult escort. Ride-share services do not qualify. I agree that I will not take these medications if I plan to drive or travel alone.

- I acknowledge that sedating, pain, or anxiety medications may impair my judgment, coordination, memory, and decision-making. I agree not to sign legal documents, make major personal or financial decisions, or be responsible for the care of others for at least 24 hours after receiving such medications.

- I understand that medications and local or regional anesthesia used during or after my procedure may cause side effects including but not limited to nausea, vomiting, dizziness, allergic reactions, respiratory depression, heart

rhythm disturbances, low blood pressure, paradoxical agitation, prolonged sedation, and, in rare cases, serious injury or death.

- I authorize Dr. Nosti and his staff to initiate emergency treatment and arrange transfer to a hospital or higher level of care if, in their medical judgment, my condition requires it. I understand that I am financially responsible for any costs associated with such care.
- I understand that individual responses to medications cannot be predicted and that emergency medical treatment or transfer to a hospital may become necessary.
- I understand that wound healing may not be perfectly symmetrical. Differences in the appearance of the labia, including uneven edges or scalloping, may occur. This may improve with time or may require revision surgery.
- I understand that healing varies from person to person, and outcomes may be unpredictable.
- I understand that tissue retraction may occur over time, and that a “rim” or visible labial edge after surgery may change to a flatter “Barbie-like” appearance as healing progresses.
- I understand that the blood supply in the area may be variable, which can impair healing and may lead to wound separation or tissue breakdown.
- I understand that non-compliance with post-operative instructions, including activity restrictions, may compromise my surgical outcome.
- I understand that I must refrain from all sexual activity for at least six (6) weeks postoperatively or until cleared by Dr. Nosti.
- I understand that scarring may result from sutures, infections, or keloid formation. Scars may be visible and may not be concealed depending on individual healing.
- I understand that bruising, swelling, and changes in skin color (lighter or darker) are expected. These may persist for several weeks and, in rare cases, may be permanent.
- I understand that temporary or permanent numbness in the surgical area can occur.
- I understand that one or more revision procedures may be necessary to achieve my desired cosmetic outcome.
- I authorize Dr. Nosti to perform additional or alternative procedures that, in his professional judgment, are necessary to address unexpected conditions or to protect my health and safety during surgery.

(initial) Revisions and Follow-up Care

- I understand that Dr. Nosti offers surgical revisions for \$500 within one (1) year of the original procedure to cover operating room (OR) fees only. No additional professional fee is charged.
- I understand that if I choose to consult another provider for revision, I am fully responsible for all associated costs.
- I understand that revisions may not be able to achieve my original aesthetic or functional goals.

- I understand that attending all post-operative appointments is essential for monitoring my healing. Dr. Nosti cannot be held responsible for any complications if I do not attend follow-up visits.
- I understand that aesthetic outcomes are subjective and based on personal perception. What I consider an acceptable or desirable cosmetic result may differ from the medical assessment of a successful surgical outcome.

(initial) Specific Procedure Considerations

- I understand that no outcome is guaranteed, and Dr. Nosti has not promised specific aesthetic or functional results.
- I understand that vaginoplasty can result in excessive tightness, which may lead to painful intercourse, internal scarring, and possible need for revision. Diligent vaginal softening exercises are required starting approximately six (6) weeks after surgery and may continue for several weeks.
- I understand that hymenoplasty may lead to initial pain or bleeding with intercourse. In some cases, no bleeding may occur. I may require a small procedure to release the hymen if it causes discomfort or fluid retention. No guarantees are made regarding bleeding during intercourse.

(initial) Consent for Photography, Video, and Public Educational Use

- I authorize Dr. Nosti and his staff to take photographs and/or video of my body before, during, and after my procedure for medical documentation and treatment purposes.
- I further authorize the use of de-identified images and/or video for public educational purposes, including but not limited to the practice's website, patient education materials, professional presentations, and online platforms, provided that my name and identifying facial features are not shown.
- I understand that once images are placed on public platforms, complete removal cannot be guaranteed. I understand that I may revoke this authorization in writing for future use, but revocation does not apply to materials already published.

(initial) Treatment Options and Decision-Making

- I have been informed of all appropriate treatment options, including:
 - Obtaining outside consultation(s)
 - Proceeding or declining surgery
 - Expectant management ("watch and wait")
 - Non-surgical (medical) treatments
- I have had the opportunity to ask questions, conduct my own research, and I voluntarily elect to proceed with the recommended procedure(s).

(initial) Financial Acknowledgment

- I understand that this is a cash-pay procedure and not covered by insurance. I accept full financial responsibility and agree to pay in advance or at the time of service.
- I understand that treatment of medical complications, including infection, wound breakdown, or hospital care, is not included in my surgical fee and may result in additional charges for which I am financially responsible.

(initial) Final Consent Statement

- I understand that this is a legal document, and my signature below confirms that I have:
 - Received, reviewed, and understood the risks, benefits, and alternatives to the procedure.
 - Had all of my questions answered to my satisfaction.
 - Received and reviewed pre-operative and post-operative instructions.
 - Been informed that I may request a copy of this signed consent for my records.
 - I understand that this consent does not waive my legal rights in the event of negligence but confirms that I have been fully informed of known risks, benefits, and alternatives.

This consent and any dispute arising from my care shall be governed by the laws of the State of Kansas, and venue shall be exclusively in the courts of Johnson County, Kansas, unless otherwise required by law.

PATIENT NAME (PRINT): _____

PATIENT SIGNATURE: _____ DATE/TIME: _____

PHYSICIAN SIGNATURE: _____ DATE/TIME: _____
Patrick Nosti, M.D., FACOG, FPMRS