BREAST EDUCATION GUIDE&PREFERENCES

This is the first step to the 24-hour Rapid Recovery. This technique has been proven to minimize complications and provide a quick, easy recovery. Our process is to provide validated information regarding breast augmentation that will not only allow you to make better decisions, it will allow us to make better decisions together.

When selecting preferences and choices, if Dr. Adams feels that your choices might have negative short-term or long-term effects on your tissues or increases the risk of complications, he will discuss these issues with me during the consultation.

CHOICES AND PREFERENCES FOR BREAST AUGMENTATION

________ The pictures below represent a way for you to voice the type of result that you desire. Although Dr. Adams will use this information to best plan your procedure, these pictures imply no warranty for your result. There are many factors that can affect the shape of the breast including the breast capsule and soft-tissue stretch that we will cover below.

1. <u>Six months after my augmentation (after my tissues relax), Please initial one of the BREAST SHAPES YOU DESIRE:</u>

A) ______

B) ______

C) ______

D) ______

2. <u>Please initial one of the following with respect to BREAST SIZE AND RISK OF FUTURE PROBLEMS:</u>

A) ______ I WANT A BREAST SIZE THAT WILL HAVE THE LEAST CHANCE OF CAUSING FUTURE SAGGING, COMPLICATONS, OR NEED FOR ADDITIONAL PROCEDURES SUCH AS A BREAST LIFT. I understand that Dr. Adams will choose an implant that will produce the fullest breast possible that is safest long-term, unless I specify a smaller or larger breast.

B) ______ I WANT A SPECIFIC BREAST SIZE, EVEN IF IT MIGHT BE LARGER THAN IDEAL FOR MY TISSUES. If I want a larger implant than Dr. Adams feels is optimal for my tissues, I understand that I may not have a natural appearing breast. I am willing to accept all responsibility for appearance and increased risks of reoperations, complications, deformities, and additional costs in the future that may result from my selecting an implant that is larger than ideal for my tissues.

C)______ EXTREMELY FULL, WITH A VERY BULGING UPPER BREAST. I understand and accept that this choice produces a breast that does not appear natural and may have excessive bulging with an unnatural appearing transition from the upper chest to the breast. I also understand that an excessively large implant can cause damage to my tissues long-term that could cause me to need additional operations or have permanent deformities, but I want the large implant regardless of those possible consequences.

3. <u>Please initial the following acknowledging BREAST LIMITATIONS:</u>

D)______ I understand that NO IMPLANT, REGARDLESS OF SIZE OR SHAPE, can guarantee upper breast fullness long-term, and the larger the implant I select, the more likely stretch of the lower breast envelope will allow loss of upper fullness.

E)______ If, after surgery, for any reason I desire a different size implant, I understand and accept that I must specify the exact type and size of implant in cc's, and that I am totally responsible for all costs associated with changing my implants, including surgeon fees, anesthesia fees, laboratory costs, and surgical facility fees.

F) ______ Dr. Adams can achieve virtually any size breast, but Dr. Adams is limited by the characteristics of my tissues that cannot change. I also understand that the choices, particularly with respect to implant size, can affect the appearance of my breasts as I get older and can affect my risks of having complications or needing additional operations in the future.

3. Please initial one of each A-C of the IMPLANT YOU DESIRE or Select for Dr. Adams to choose:

A) Preferred Implant Shape

____ Shaped ____ Round

____ Textured ____ Smooth

B) Preferred Implant Type

____Saline ____Cohesive Silicone

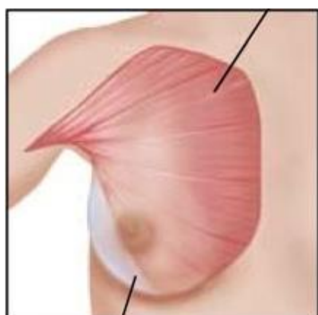
____ Do you have a preferred cc amount? _____ cc

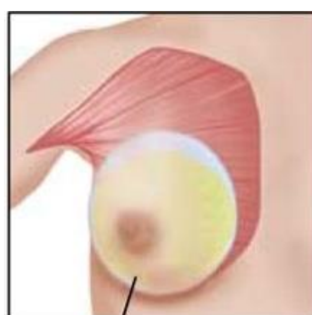
C) Preferred Implant Manufacturer

_____ Allergan Natrelle _____Mentor _____ Sientra

D) _____ I absolutely have no preferences on implant manufacturer, type, shape or size and want Dr. Adams to choose based on his evaluation of my tissues and proportions. I am leaving the decision entirely up to Dr. Adams, and I will accept his judgment regardless of my breast size following surgery. I understand that Dr. Adams will fill my breast as much as he feels it can be filled safely, without producing additional risks or tradeoffs. I understand and accept that Dr. Adams cannot guarantee a cup size of my result, and I will not request a larger implant following my augmentation.

4. Please initial the IMPLANT POCKET LOCATION you prefer or Select for Dr. Adams to choose:



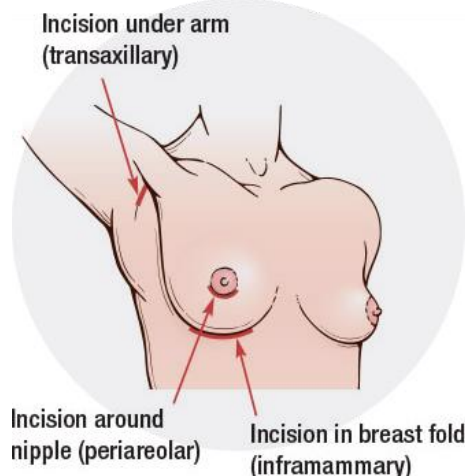


A) ____ I prefer my implant be placed UNDER the muscle.

B) ____ I prefer my implant be placed ABOVE the muscle.

C) ____ I do not have a preference for over or under muscle, and I want Dr. Adams to choose according to my tissue.

5. Please initial the IMPLANT POCKET LOCATION you prefer or Select for Dr. Adams to choose:



A) ____ Under the breast

B) ____ Around the areola

C) ____ In the armpit

D) ____ I would like Dr. Adams to choose my incision location based on his assessment of my needs and optimal control during the operation, and I will abide by his decision.

FACTORS FOLLOWING MY AUGMENTATION THAT DR. ADAMS CANNOT CONTROL

My healing characteristics listed below can affect my results following breast augmentation, and can require a need for additional surgery, and costs.

TISSUE STRETCH

6. _____ I understand and accept that Dr. Adams must work with what I bring him to work with, and that he cannot change the qualities of the tissues of my breasts that affect stretch following surgery or how I will heal. I also understand and accept that Dr. Adams cannot perform tests before surgery, or in any other way to predict how my skin will stretch following my augmentation.

7. _____ If my tissues stretch excessively in any area following my augmentation, deformities can result which Dr. Adams has no control. These deformities include the following:

a) excessive sagging or "bottoming out" of the breast with the implant too low and the nipple pointing excessively upwards.

b) shift of the implants to the sides with widening of the gap between the breasts.

c) thinning of tissues over the implant allowing the implant to become visible or palpable (able to be felt) in any area.

d) visible rippling in any area that can result when the implant pulls on the overlying tissues.

INFECTION

8. ______ I fully understand and accept that if I develop an infection following my augmentation, Dr. Adams will remove one or both my breast implant. If an implant(s) is removed secondary to infection Dr. Adams will discuss the pros and cons of replacement with me. Never replacing implants may also be an option to minimize further reoperations, risks, and costs to me. If I decide to replace the implant, a period of time will be required following removal to allow my breast tissue to heal and soften. This usually is 3- 6 months. I further understand and accept that, if implant removal is ever required for any reason, that deformities may result that may not be totally correctable.

CAPSULAR CONTRACTURE AND WOUND HEALING

9. ______ I understand and accept that my body will form a lining (capsule) around my breast implant following my augmentation, and that the capsule around the implant may contract (tighten) excessively, causing a variety of deformities that may require additional surgery and despite additional surgery, may be uncorrectable and require implant removal. The capsules that form and the amount that they tighten are never equal on both sides, so the effects of the capsule on each breast are usually different.

10. ______ I understand and accept there are no tests or medical information that can accurately predict whether my capsules will tighten excessively following my augmentation. Dr. Adams has no control on how my body forms the capsule or how much the capsule will tighten or cause deformity. Dr. Adams cannot predict, prevent, or control the occurrence of any of these deformities:

a) Closing of a portion of the lower implant pocket (can be mild or severe), causing slight or significant upward displacement of the implant, and raising the fold under the breast leaving the incision scar below the fold.
b) Closing of a portion of the outside of the implant pocket, causing flattening of areas of the outside contour of the breast and inward displacement of the implant.
c) Excessive firmness of the implant or breast
d) Visible edges or bulging deformities in any area of the breast
e) The effects of my body healing and scarring in the area of the incision, adjacent areas to the incision or breast, or any area of the breast.
f) Discomfort or pain in areas of the breast
g) Change in sensation or loss of sensation in any area of the breast or adjacent areas.
h) Occurrence of lymph node enlargement or small bands near the incision caused by incision or obstruction of small lymph vessels (both of which usually subside without treatment in 3-6 weeks).

11. _____ I understand and accept that if any or all of the deformities listed above, tissue stretch, infection, wound healing, and/ or capsular contracture should occur, even though the deformity may be visible, Dr. Adams alone will determine whether additional surgery is needed. Dr. Adams will base this decision on whether he feels the potential benefits outweigh the potential risks of additional surgery and whether he feels I will get predictable improvement from additional surgery.

12. _____ I understand and accept that Dr. Adams has absolutely no control over how my body heals following my breast augmentation, and that he cannot predict (by tests prior to surgery) or control my individual healing characteristics.

13. _____ I understand and accept that if any of the deformities listed above occur following my augmentation, that additional surgery will not change the qualities of my tissues, stretch and healing characteristics that caused the stretch and/ or deformity in the first place. As a result, additional surgery to correct these deformities a) is unpredictable at best due to the limitations of my skin, tissues and healing characteristics, b) that surgery for any of the deformities listed above may not successfully correct the deformity, and c) that any or all of these deformities can occur again after additional surgery because of my healing characteristics.

14. _____ I understand and accept that any or all of these deformities can occur in one or both breasts, and do not occur equally on the two sides. Although breasts never match exactly on the two sides, if any of these deformities occur, differences in the two breasts may be more noticeable and may not be correctable.

15. _____ I understand and accept that costs of any additional surgery following my augmentation will likely exceed the costs of my original augmentation surgery, and costs are determined by the complexity and duration of the surgery required. Fees for additional surgery will include laboratory fees, possible mammogram or MRI imaging fees, Dr. Adams' surgeon fees, anesthesia fees, surgical facility fees, and costs of prescriptions. I accept personal responsibility for all of these fees.

HOW DID WE DO INFORMING YOU?

I ____ have read Dr. Adams' Breast Education Guide and have had an opportunity to speak with Dr. Adams' patient educator, Christy Aguilar. I have had an opportunity to ask questions and have had all of my questions answered to my satisfaction. I will have an additional opportunity to ask Dr. Adams questions during our consultation.

16. _____ I fully understand and accept that perfection is not an option, improvement with tradeoffs is the best we can hope for. No choice we can make is without tradeoffs and risks.

17. _____ I fully understand and accept that no woman has two breasts that match, and that no surgeon can produce two breasts that exactly match. I understand and accept that Dr. Adams will try his best to equalize my breasts as much visually possible given my tissues and their limitations, but my breasts will not match after surgery.

18. _____ I fully understand and accept that the larger we make my breasts, the worse they will look as I get older, the greater the risks of tissue thinning and/or visible rippling, and the greater the risk of additional surgeries with additional risks and costs.

14. _____ I fully understand and accept that Dr. Adams cannot and will not guarantee me a specific cup size breast, because cup size is not a consistent or predictable clinical measurement, cup size varies among bra manufacturers, and I may choose to wear a bra that is larger or smaller to produce a certain look of my breasts or for comfort or style reasons.

19. _____ I fully understand and accept that if I have thin tissues in any area, that I will likely feel the edge or the shell of my implant. If I can feel my ribs with my finger beneath my breast, I may feel the edge of my implants. If my tissues are extremely thin, I may even see a portion of the implant shell or an implant edge. Dr. Adams will make every effort to provide as much tissue coverage as my tissues will allow to minimize these risks, but he is limited by the quality and thickness of my tissues.

20. _____ I fully understand and accept that Dr. Adams cannot predict or control the amount that my tissues may stretch following augmentation. The larger the implant we choose, the more the tissues will stretch, but even with an implant that seems appropriate for my tissues, it is possible for my tissues to stretch excessively or unevenly in one breast or the other. If this occurs, breast shape or position may be different on the two sides, nipple tilt or position may be different, and additional surgery may be required to attempt to correct excess stretching deformities.

21. _____ I fully understand and accept that if my implants ever need to be removed for any reason, the appearance of my breasts will be compromised. The larger the implant that I choose, the worse the appearance of my breasts will be, and the greater the risks of additional surgery with additional costs and risks.

22. _____ I understand and accept that Dr. Adams cannot read my mind, and it is my complete responsibility to be absolutely honest in my requests. I have absolutely no other requests, or expectations other than those specifically defined in the written documents I have completed and signed.

23. _____ I am confident and comfortable that I have completely and honestly specified my desires and expectations in the written documents I have completed for Dr. Adams. I also understand if any information changes prior to surgery, it is my responsibility to see that new, written documents are completed and signed by me. I understand and accept that Dr. Adams will NOT consider any verbal communications without written confirmation and documentation signed by me.

24. _____ If, for any reason in the future, I commence, join in, or in any other manner attempt to assert any legal claim or cause of action against Dr. Adams for any item in this form that I have specifically acknowledged responsibility for by my initial or signature, I agree to pay all of Dr. Adams' attorney's fees associated with defending my claim or cause of action.

25. _____ I fully understand and accept that capsular contracture, tissue stretch, and infection cannot be predicted or prevented. There are no tests or facts in my medical history that will allow Dr. Adams to predict whether I will develop capsular contracture, tissue stretch or infection in one or both breasts. There are no implants or surgical techniques that can assure that I will not develop capsular contracture, tissue stretch or infection. If I develop another capsular contracture after the first correction, Dr. Adams will recommend removal of both implants without replacement as the safest and best option to prevent an excessive number of reoperations. Additional reoperations could result in greater risks of tissue thinning and/or visible rippling, greater risks of additional surgeries with additional risks and costs; and could result in permanent deformities.

26. _____ I fully understand and accept that I will be totally responsible for additional surgeon, facility, lab, prescription and anesthesia fees, as well as possible additional lost time off work or normal activities for three specific conditions: 1) Capsular contracture (excessive firmness or pocket closure in any area that causes implant displacement or deformity), 2) any deformity caused by excessive stretching of the breast skin in any area, producing excessive "bottoming" or implant displacement, excessive sagging, thinning or other stretch deformity, and 3) any exchange of breast implants for any reason, pocket closure problem that could result in breast deformity or malposition of my implants, including a change in breast implant size or shape.

I feel fully informed, and have had an opportunity to have all of my questions answered to my satisfaction.

___________________________	___________________________	______________
Patient (Please print)	Patient (Please sign)	Date
___________________________	___________________________	______________
Witness (Please print)	Witness (Please sign)	Date

______ I acknowledge this document serves as copy for your personal records (Please Download)