



Feathering and Revision *Procedure Consent Form*

I request and authorize Dr. Red Alinsod to perform Feathering and Revision and/or any other treatment in his judgment determined advisable for my well-being to optimize the aesthetic appearance and function of my vulvovaginal and anal areas. He may use radiosurgery, electrocautery, laser or any method he deems best for best for me.

The nature and purpose of the procedure as well as alternative methods of treatment have been discussed with me and I understand them. The risks and complications involved include the following:

- Pain, irritation, and discomfort with prolonged discharge
- Infection, need for antibiotics, need for wound care and debridement
- Nerve Injury, hyper or hyposensitivity
- Bleeding with possible need for suturing
- Failed Procedure with need for revision surgery
- Scarring and keloid
- Hyperpigmentation
- Hypopigmentation
- Recurrence of symptoms or lesion with skin irregularity
- Poor aesthetic results
- Fissures and skin breaks

The above noted items have been fully explained to me and I understand them. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made as to the outcomes of the procedures and/or treatments performed. I understand this is a purely elective procedure and the alternative is to cancel the procedure, get further opinions, and to delay the procedure.

I have a clear mind and I have read and understand all information presented to me before signing this consent. I have also been given the opportunity to ask questions and understand the information provided.

I hereby agree and consent to have the Feathering and Revision performed and to follow all post-treatment protocols. I have received and reviewed those protocols and understand them.

Signature: _____ Date: _____ Time: _____

Witness: _____ Date: _____ Time: _____