FEEL BEAUTIFUL
PLASTIC SURGERY

CORNER LIP LIFT (ANGULOPLASTY)

INSTRUCTIONS

Please become fully informed about corner lip lift (anguloplasty) surgery before proceeding with the operation. It is Dr. Laverson's responsibility to provide this information for you. It is your responsibility to become familiar with this information and to consider it when deciding whether or not to proceed. Read each paragraph completely. If you have questions or there are words you don't know, ask Dr. Laverson. Surgery is not an exact science. Because it is impossible to predict your outcome precisely in advance of the procedure, you should understand risks and possible complications of anguloplasty. Your signature below confirms your understanding and your request for cosmetic surgery of the lip corners and/or adjacent areas.

INTRODUCTION

Lifting of the corners of your lips is a technically demanding plastic surgical procedure performed to change position and shape the corners of your lips to:

- Improve lip shape and/or symmetry.
- Lift down-turned lip ends to change interpretations of your facial expression
- Restore youthful features to aging lips.
- Decrease visibility of shadows and/or creases around lips.

Corner lip lift is accomplished by surgically re-arranging tissue at the ends of your lips to achieve desired aesthetic outcomes. The necessary scars will be as inconspicuous as possible, at the corners of your mouth. The shadows, the creases (if any), and the shape of your lips prior to surgery will influence the surgical approach and your final result.

Patients undergoing corner lip lift surgery must consider the following:

- Corner lip lift may not be a one-time surgery.
- Changes that occur to the lip following corner lift may not be reversible.

ALTERNATIVE TREATMENTS

Corner lip lift is an elective surgical operation. Alternative treatment consists of not having the surgical procedure or use of injectable filler to enhance/rebuild lip creases. Risks and potential complications are also associated with alternative treatments.

RISKS OF CORNER LIFT LIP SURGERY

Every surgical procedure involves risk and the potential for unanticipated complications. If complications were completely predictable, they would never happen. The very nature of complications of surgery is that they are often unpredictable. The best we can hope for is to understand the most likely complications, try our absolute best to avoid them, and manage them expeditiously and successfully when they do occur. It is also important that you understand **limitations** of the corner lip lift procedure.

Inherent Risk of Corner Lip Lift Procedures

Bleeding, bruising, swelling, scarring, infection, pain, skin discoloration, asymmetry, delayed healing, dissatisfaction with results, need/ desire for revision, others.

Smoking, Vaping, Juuling, E-cigarettes, Second-Hand Smoke, and other Nicotine Products (Patch, Gum, Nasal Spray)

Patients who are currently smoking, using tobacco products, or nicotine products (vaping, juuling, e-cigarettes, patch, gum, nasal spray, etc.) have increased risk of complications such as dead, foul smelling skin, delayed healing, and additional scarring. Individuals exposed to second-hand smoke also have elevated risk for these complications, attributable to nicotine. Smoking has a negative effect on anesthesia and recovery from anesthesia, with coughing and possibly increased bleeding. Individuals who are not exposed to tobacco smoke or nicotine-containing products have less risk for these complications.

Completely stop all smoking for **at least** 3 weeks (preferably longer) before surgery and until Dr. Laverson states it is safe to return, if desired.

ADDITIONAL SURGERY NECESSARY (Re-operations)

It is unknown how wound healing will occur after surgery. Secondary surgery may be necessary at some time in the future to correct or to improve your cosmetic result. Should complications occur, additional surgery or other treatments may be necessary. Although good results are expected, there is no expressed or implied guarantee or warranty of a satisfactory result. In some situations, it may not be possible to achieve optimal results with a single surgical procedure.

PATIENT COMPLIANCE

Follow all physician instructions carefully; This is essential for a good outcome. Healing is a gradual process (weeks to months). Surgical incisions should not be subjected to excessive force, swelling, abrasion, or motion during the time of healing. Cosmetics and/or consumer skin care products should not be applied to sutured wounds. Successful recovery depends on how the surgery is performed, but also on your care and activity during the days and weeks after the procedure when your body is healing and your tissues are repairing. Physical activity that increases your pulse or heart rate may cause bruising, swelling, fluid accumulation around the surgical site and the need for return to surgery. Participate in follow-up care, return for aftercare, and promote your recovery by resting and allowing your body to heal after surgery.

FINANCIAL RESPONSIBILITIES

The cost of surgery combines several charges for services provided. Surgical fees, staff and office expenses, supplies, and equipment are all included, and are required for safe surgery. Fees charged for this procedure do not include future costs for additional procedures that you elect to have or require in order to revise, optimize, or complete your outcome. Additional expenses may be incurred if complications develop from surgery. Secondary surgery or revision surgery will also be your responsibility. **In signing the consent for this surgery/procedure, you acknowledge that you have been informed about the most common (above) associated risks and consequences. When you sign, you are also accepting responsibility for the clinical decisions that were made (surgical approach) along with the financial costs of all future treatments.**

It is important that you read the above information carefully and have all of your questions answered before signing the consent.

CONSENT FOR CORNER LIP LIFT (ANGULOPLASTY) SURGERY

1. Dr. Steve Laverson and assistant(s) are requested and authorized to perform CORNER OF LIP LIFT / ANGULOPLASTY upon me. I have read and understand the above information about corner lip lift (cosmetic lip surgery), and my questions have been answered.

2. Although truly rare, during the course of the operation, unforeseen conditions may necessitate different and/or additional procedures. Dr. Laverson is authorized to perform such procedures that are in his professional judgment necessary, desirable, and in my own best interest. The authority granted under this paragraph shall include conditions that require treatment and are not known to Dr. Laverson at the commencement of surgery.

3. I consent to the administration of anesthetics considered necessary or advisable. Anesthesia involves a small risk and the possibility of complications, injury, and rarely death.

4. NO GUARANTEE has been expressed or implied by anyone about the results of surgery.

5. My final result doesn't become apparent until at least six months following my procedure. I understand the most important office visits happen at that future time. Committing to corner of lip lift implies my agreement and commitment to follow up 6 -12 months after the procedure.

6. I consent to the disposal of any tissue, medical devices or body parts which may be removed.

7. Photography is essential medical documentation before and after cosmetic surgery, and is important in my care. My facial photographs may be used for medical, scientific, and/or educational purposes, provided personally identifiable information (my name) is not associated with the pictures.

8. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
   a. COSMETIC CORNER OF LIP LIFT (ANGULOPLASTY)
   b. ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
   c. RISKS AND COMPLICATIONS ASSOCIATED WITH ANGULOPLASTY

I CONSENT TO CORNER OF LIP LIFT SURGERY AND THE ABOVE LISTED ITEMS (1-8). I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS, MY QUESTIONS HAVE BEEN ANSWERED, AND I AM SATISFIED WITH THE EXPLANATION.

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Patient or Person Authorized to Sign for Patient

_____

Printed Name

Date_____ _____Witness