OUT-OF-TOWN SURGERY CONSENT & ACKNOWLEDGMENT FORM

AESTHERA PLASTIC SURGERY
2021 Peachtree Rd, Suite 325
Atlanta, GA
(404) 446-0044

Patient Information:

Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Home Address: _____

1. Purpose of This Form:

This document is intended to confirm that you, the patient, understand and accept the risks and responsibilities involved in traveling to Atlanta for elective plastic surgery. It outlines your obligations before and after surgery, particularly related to travel, recovery, and follow-up care.

Initials: _____

2. Pre-Operative Acknowledgments:

I understand and acknowledge that:

☐ I am traveling from outside the Atlanta area specifically for elective plastic surgery.

☐ I have disclosed my complete medical history, including medications, allergies, and recent illnesses.

☐ I have been evaluated (virtually or in person) and deemed a suitable candidate for surgery.

☐ I am responsible for obtaining pre-operative medical clearance if requested by my surgeon.

☐ I will arrive in Atlanta at least 1–2 days before surgery and will be available for a pre-operative consultation.

Initials: _____

3. Travel and Accommodations:

☐ I am responsible for all travel and lodging arrangements during my stay in Atlanta.

☐ I understand that post-operative air travel should be avoided for a minimum of 5–10 days (or as recommended by my surgeon).

☐ I acknowledge that traveling shortly after surgery increases the risk of blood clots, infection, and other complications.

☐ I will have a responsible adult with me for the first 24–48 hours post-surgery, or I will use a licensed medical recovery service.

☐ I understand that driving myself after surgery or while on narcotic medications is strictly prohibited.

Initials: _____

4. Post-Operative Care:

☐ I will stay in Atlanta for at least 5–7 days after surgery (or longer, depending on the procedure and surgeon's recommendations).

☐ I will attend all scheduled post-operative appointments during my stay.

☐ I understand that if complications arise after I return home, I may need to seek care locally or travel back to Atlanta.

☐ I am financially responsible for any emergency care, hospital admission, or revision surgery not covered by insurance.

☐ My long-term follow-up may include virtual check-ins and photo submissions, as advised.

Initials: _____

5. Risk and Responsibility:

☐ I understand that having surgery far from home carries unique risks, including difficulty accessing care if complications arise after I return home.

☐ I assume full responsibility for any medical needs that arise after leaving Atlanta.

☐ I will maintain regular communication with the surgeon’s office and promptly report concerns.

☐ I understand that this is an elective plastic surgery procedure.

☐ I am responsible for the full payment of out-of-pocket costs not covered by insurance, and travel-related costs.

☐ I have read and understood the surgical consent forms provided separately.

Initials: _____

6. Final Confirmation:

By signing below, I confirm that:

- I have read this document in its entirety.
- I have had the opportunity to ask questions and receive answers.
- I accept the risks and responsibilities of traveling for surgery.
- I agree to comply with all medical and logistical recommendations before and after surgery.

Patient Signature: _____
Date:_____

Witness or Office Staff: _____
Date:_____