INFORMED CONSENT FOR REPAIR OF NASAL VALVE COLLAPSE

BOISE ENT™

Dr. Don J Beasley, MD
Camille Buchmiller, PA-C
208-229-2368

I hereby authorize Dr. Beasley to treat my right/left/bilateral nasal valve collapse (stenosis). The physician explained that the absorbable nasal implant (Latera) used is a commercially available product, specifically cleared by the FDA to be used as a treatment for my condition, nasal valve collapse (stenosis).

Dr. Beasley has explained that common symptoms of nasal valve collapse include nasal obstruction and decreased nasal airflow. Satisfactory treatment of nasal valve collapse is achieved by placing an absorbable nasal implant (Latera) into the lateral nasal wall. The general nature of the procedure for treatment of has been explained to me. I understand that the known risks of this procedure include, but are not limited to:

- Mild pain or irritation
- Mild bruising or swelling
- Continued or worsening symptoms

I am aware that in addition to the risks specifically described above, there are other risks that may accompany any surgical procedure, such as bleeding, infection, and scar formation which may require additional medication or surgical intervention, as determined by the physician. I have read, signed, and dated this form prior to the service listed above being rendered to me.

☐ I consent to the photographing, filming, or videotaping of the treatment or procedure for educational or diagnostic use.

☐ I do not wish to have any photographing, filming, or videotaping of the treatment or procedure for any use.

Patient Name: _____ Account#: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____