InfantEar™ Molding Procedure Consent Form

[*For completion at conclusion of informed consent discussion*]

_____1. I consent to the performance of the following procedure: Ear molding using the InfantEar™ System to correct my
Initials child's (name): _____ deformed ear(s).

The purpose of this procedure is to reshape my infant's deformed ear(s). This molding procedure does not involve any surgery and will be performed by Dr. Julio Guerra and/or Michelle Bartlett, APN and whomever they may designate as assistants. The duration of the molding treatment is between 2-4 weeks.

____2. Dr. Guerra and/or Michelle Bartlett, APN have explained the nature and purpose of the ear molding procedure and
Initials *the benefits and risks of* the procedure and the possibilities of complications to my infant.

_____3. Dr. Guerra and/or Michelle Bartlett, APN have explained to me that a satisfactory result is expected, but the following
Initials *are some of the c*omplications or effects that could or may occur: bleeding, infection, inflammation to adjacent tissues, swelling, and or discomfort.

_____4. No one has given me a guarantee or assurance about the results that may be obtained. I understand that there are
Initials many factors that determine the final cosmetic outcome.

_____ 5. I was invited and encouraged to ask any questions I may have. All of my questions have been answered to my
Initials satisfaction. I have read and understand the contents of this form, and I wish to proceed.

_____ _____

Witness Patient, parent or person authorized to sign for patient *(please print)*

Date: _____ _____

Signature of patient, parent or person authorized to sign for patient