



AESTHETIC FACIAL PLASTIC SURGERY PLLC
DR. PHILIP YOUNG, MD

Healing Body & Mind

Once you have the procedure you waited a long time for, it is time to be patient and wait, again, for your body to heal. Unfortunately, a surgeon's scalpel is not a magic wand and healing will occur at different rates for different people. You must allow yourself to heal and be aware it is natural to be impatient for the results and a little anxious because you often look worse before you look better. Being aware this can happen will help you understand these normal feelings.

Sharing your experience with friends and family can help give you a support system during your recovery, but realize they may unintentionally make you question your decision with concerns during your recovery. While you may think that you are looking pretty rough around the edges, we may tell you that you are healing beautifully. Trust us. We will share with you if there is a concern, so if we tell you that everything is healing normally, it is.

Your healing will depend on many things such as your general health, your willingness to follow instructions, and your mental attitude toward recovery. While I can perform the surgery, I cannot "heal" you. It is up to you to be an active participant in your recovery process to help your body heal the best that it can. Following all of our instruction is very important, as is working with us to address any complications that may arise. Even surgeries that are done exactly right, can have complications during recovery. It has to do with the human factor. We are not machines and every person can react differently and heal differently even when the surgery is done exactly the same. Every surgeon has unexpected results from time to time.

It is important you approach your surgery and especially your recovery with the mindset that we are a team, and you are an integral part of that team. We must trust each other to be working for a common goal, your successful result. As the surgeon, I enjoy my work and strive to achieve an ideal result during every surgery for every patient. I have rigorous standards that my staff must meet in order to be involved in your care. I am looking forward to working with you to achieve a great result and do not anticipate any post-operative problems. I will do everything I can to make sure that you are happy with your result.



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Your Anesthesia Experience

Anytime you undergo anesthesia, your general health condition must be considered. Depending on your age and the results of your history and physical, you may need pre-operative testing such as blood work, chest x-ray, or EKG. This is done to ensure that your current health does not put you at any additional unnecessary risk while under anesthesia.

There Are Four Levels Of Sedation That We Offer:

- 1. Local Sedation**
A local anesthetic agent such as Novocaine, Xylocaine, or Marcaine is introduced in to the tissue through injection and produces a numbness that allows surgery to be carried out with little to no discomfort while the patient is awake.
- 2. Oral Sedation**
Local sedation is used in conjunction with Valium (sedative), Percocet (pain medication), and Phenergan (anti-nausea medication) which are ingested orally. You will experience little to no discomfort; be aware and conscious but fairly relaxed; and responsive to voice.
- 3. Conscious Sedation with Registered Nurse and Dr. Young**
Versed or Fentanyl is administered through an intravenous line by our nurse. This level is a little deeper state of sedation. You will be very sleepy but still responsive to more forceful amounts of voice and touch. Some refer to this type of sedation as Twilight.
- 4. Conscious Sedation with a Certified Registered Nurse Anesthetist**
The last type of anesthesia offered is administered through an intravenous line given by a Certified Registered Nurse Anesthetist. This level can allow you to go into a deeper state of conscious sedation where you require more stimulation through touch and voice to become responsive. With this level of sedation, you will be much less aware of what is going on during the procedure than the other levels.

We ask that you strictly avoid food and liquids after midnight the day before your procedure or at least 8 hours before your procedure. This is done for your protection to empty your stomach and prevent aspiration of food or fluid from the stomach into the lungs during anesthesia. If you are just having local anesthesia with your procedure and no sedation with Dr. Young, you may be allowed to have something light before your procedure BUT YOU SHOULD ASK DR. YOUNG BEFORE DOING THIS.

Either prior to or on the day of surgery, your anesthesiologist will have questions for you regarding your health, height, weight and past anesthesia experiences. Complete and honest answers are required to assist your anesthesiologist in planning and administering the safest level of anesthetic possible. As you wake up from your anesthesia, your vitals will still be monitored closely for an hour. Often you will be given additional medications for discomfort and/or nausea. Once you are awake and aware, you may be released to a responsible adult to go home with you. Please follow the post-operative instructions closely regarding supervision requirements and activity restrictions. Drinking lots of fluids will help rid your body of the medications used for anesthesia more quickly.



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Pre-Procedure Instructions – General

The following instructions should be followed closely except when overruled by specific procedural instructions.

Two Weeks Prior to Your Procedure and After Procedure

1. NO ASPIRIN or medicines that contain aspirin* since it interferes with normal blood clotting.
2. NO IBUPROFEN or medicines contain ibuprofen* as it interferes with blood clotting.
3. Please DISCONTINUE ALL HERBAL MEDICATIONS* as many have side effects that could complicate a surgical procedure by inhibiting blood clotting, affecting blood pressure, or interfering with anesthetics.
4. Please DISCONTINUE ALL DIET PILLS whether prescription, over-the-counter or herbal as many will interfere with anesthesia and can cause cardiovascular concerns.
5. NO “MEGADOSES” OF VITAMIN E (which is anything greater than 40IU), but a multiple vitamin that contains E is just fine.
6. NO SMOKING because nicotine reduces blood flow to the skin and can cause significant complications during healing.
7. You may take Tylenol or generic forms of this drug. These do not interfere with blood clotting or healing.
8. Start taking a multivitamin each day and continue taking through your recovery. The healthier you are, the quicker your recovery will be.

One Week Prior to Your Procedure

9. DO NOT take or drink any alcohol or drugs for one week prior to your procedure and one week after your procedure as these can interfere with anesthesia and affect blood clotting.
10. DO NOT color your hair from this point on and for one month after your procedure.
11. If your skin tolerates, use a germ-inhibiting soap for bathing, such as Dial, Safeguard, or Lever 2000 for at least the week before your procedure.
12. DO report any signs of cold, infection, boils, or pustules appearing before your procedure.



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13. DO NOT take any cough or cold medications without permission.
14. DO arrange for a responsible adult to drive you to and from the facility on the day of your procedure, since you will not be allowed to leave on your own.
15. DO arrange for a responsible individual to spend the first 24 hours with you, since you CANNOT be left alone.

Night Before Your Procedure and Morning of Your procedure

16. DO NOT eat or drink anything (not even water) after midnight the night before your procedure. Also, no gum, candy, mints or coffee the morning of your procedure. Do not sneak anything as this may endanger you. If you are just having your procedure under local anesthesia in our office you can eat something light up until your procedure. **If you are having oral or conscious sedation you should have nothing to eat or drink (but you can have a little sip of water to take your usual medications) after midnight the night before your procedure.**
17. If you are on regular medications, please clear these with Dr. Young. If given clonidine you should take one dose the morning on the day before your procedure and one the night before your procedure.
18. DO take a thorough shower with your germ-inhibiting soap the night before and the morning of your procedure. Shampoo your hair the morning of your procedure. This is to decrease the bacteria on the skin and thereby decrease the risk of infection.
19. DO NOT apply any of the following to your skin, hair or face the morning of your procedure: make-up, creams, lotions, hair gels, sprays, perfumes, powder, or deodorant. Using any of these products will add bacteria to the skin and increase the risk of infection.
20. You may brush your teeth the morning of your procedure but do not drink anything unless you are having the procedure in our office under local anesthesia without oral or conscious sedation.
21. DO NOT wear contacts to your procedure. If you do wear glasses, bring your eyeglass case.
22. DO wear comfortable, loose-fitting clothes that do not have to be put on over your head. The best thing to wear home is a button-up top and pull on pants. You will want easy-to-slip-on flat shoes.
23. DO NOT bring any valuables or wear any jewelry (no rings, earrings, chains, toe rings, other metal piercings or watches). We will need to tape wedding rings if worn.



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24. You must have an adult drive for you – to and from your procedure. Please note that a cab or bus driver will not be allowed to take you home after your procedure. On arrival, be sure we know your driver's name, phone numbers, and how we will be able to reach them.
25. If you are not recovering at home, it is very important that we have the number where you will be after your procedure.



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CO2 Laser Treatment Before and After Instructions

Congratulations on completing your procedure (or the procedure you are about to complete). The following instructions have been created for you. If you have any questions please call us at 425-990-3223. Dr Young can be reached at the same number. If you reach our voice mail there are other numbers that you can reach Dr Young for an emergency. But for true emergencies you should call 911.

The following health conditions are contraindicated for CO2 laser resurfacing. If you have a history of any of the following; you may need to reconsider having CO2 laser resurfacing treatment.

- Current or history of cancer, especially malignant melanoma, or recurrent non-melanoma skin cancer, or pre-cancerous lesions such as multiple dysplastic nevi.
- Any active infection.
- Disease which may be stimulated by light at 560nm to 1200nm, such as history of recurrent Herpes simplex, systemic lupus erythematosus, or porphyria.
- Use of photosensitive medication and / or herbs that may cause sensitivity to 560-1200m light exposure such as Isotretinoin, tetracycline, or St John's Wort (Best Avoided for at least one year before your resurfacing).
- Immunosuppressive disease, including AIDS and HIV infection, or use of immunosuppressive medications.
- Patient history of hormonal or endocrine disorders, such as polycystic ovary syndrome or diabetes, unless under control.
- History of bleeding coagulopathies, or use of anticoagulants.
- History of keloid or hypertrophic scarring.
- Very dry skin.
- Exposure to sun or artificial tanning during the 3-4 weeks prior to treatment. Sunblock should be applied 2 weeks or more before your procedure using a product that is sensitive for the skin and contains titanium dioxide or zinc oxide-containing sunblock.
- Skin type V1 or very dark, black skin types.
- Pregnancy and nursing.
- Ectropion, outward turning of the lower eyelid and excessively dry eyes, previous lower Blepharoplasty.
- Koebnerizing diseases, prior radiation therapy leading to a loss of adnexal structures, extensive fibrosis resulting from prior cosmetic treatments (e.g., dermabrasion, deep chemical peels, silicone injections).



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Before Your Laser Treatment:

- Have On Hand:
 - Cetaphil or SkinMedica Sensitive Cleanser or other gentle cleanser
 - White vinegar for post-treatment cleaning
 - Vaseline
 - Hydrocortisone 1% OTC
 - Oral Benadryl
 - SPF 30, such as SkinMedica Environmental Defense
 - Gentle moisturizer, such as SkinMedica TNS Ceramide Treatment Cream
 - Mineral makeup
 - Frozen washcloths (dip washcloths in water, fold and place in freezer, or frozen peas or frozen ice bag)
 - Artificial Tears and Eye lubricant, such as Systane or Lacrilube

- You will be prescribed the following medication or other medicines, based on your needs: Tretinoin (RetinA / retinol complex), Hydroquinone (epiquin), Tylenol #3, Keflex or Clindamycin, and Valtrex.

- 4 – 5 weeks before treatment, read through the medication information at www.rxlist.com to see if there is any reason you should not use these topical medications: Tretinoin (RetinA), Hydrocortisone and Hydroquinone.

- Start ONE of these prescriptions, applying a light layer and waiting several days for all of the redness to go away before starting the next coat. Repeat until you are able to use them as directed below. After the first medication is tolerated at max doses, then start the next medication in the same way. All three of these medications should eventually be used at the same time:
 - Apply Tretinoin (RetinA) 0.025% gel at night (Qhs); it will be in 45g tube.
 - Apply Hydroquinone 4% gel and Hydrocortisone and build up to twice a day (morning and night); 45g tube.
 - Do NOT expose your skin to sun. Make sure to apply SPF 20 or greater daily.
 - Do not use self-tanning products.

- 2 weeks before your treatment you should decrease alcohol consumption.

- 1 week before your treatment you should:
 - STOP the Tretinoin, Hydrocortisone and Hydroquinone and make sure that you have been on these for at least 2 weeks and better 4 weeks before stopping them;
 - STOP DRINKING ALCOHOL.



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- 3 days before your laser treatment, start Valtrex 500mg orally twice daily and continue for a total of 10 days.
- 1 day before call to make sure that you have all of your questions answered.
- On the day of your procedure, come to the office with a clean face; no eye make-up, no lotion, no sunscreen. Be sure to be on time. You may need extra time for topical anesthetic. Do not wear contact lenses. You will need someone to drive you home.
- 1 hour before the treatment, you will take antibiotics, either:
 - Keflex 500 mg orally 4 times a day and continue for 7 days;
 - If you are allergic to Penicillin or Cephalosporins, you might be prescribed Clindamycin 300 mg orally 4 times a day.

After Your Laser Treatment:

- Be prepared for swollen eyes, crustiness, peeling and itching for several days after the procedures. Day by day improvement is exciting, but the first 4-5 days can be challenging.
- Keep the area cool with cold compresses. Avoid direct sunlight walking to your car.
- Turn on the air conditioner and aim it at your treated area for the ride home.
- If you wear glasses, place a piece of gauze between the bridge of your nose and glasses to avoid irritation.
- You can start taking your pain medication, but do not take so much as to make you drowsy. Keep your pain level around 3-4 on a scale of 10, where 10 is the worst pain that you have ever experienced in your life and 0 is no pain. You should not have your pain at level 0. This could be a dangerous amount of pain medication that you are using to keep your pain at this level.
- You can shower but never let the water directly hit the areas that were exposed to the laser and should avoid hot temperatures, keep it lukewarm for the first 2 weeks
- You should avoid hot (temperature) and spicy foods and keep everything bland in your diet for the first 2 weeks.
- You should never remove the crusts by peeling them off. They should fall off naturally with your constant cleansing of your skin as described below.

First 2-4 Hours After Treatment:

- You can take an analgesic (e.g., Acetaminophen) for discomfort. We will also prescribe a pain medication for you to take if needed.
- Apply cool compresses to treated areas, but try to avoid direct contact to skin. Put a cloth between the cooling agent and the skin. You can ice your treated areas 15min every hour.



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- You may blow air from a fan to help with the cooling.
- When intense heat subsides, start cleaning:
- Wash your face every 2-3 hours and more if you have more crusting, by lathering your hands with Cetaphil or gentle cleanser. Pat the soap on your face without any rubbing. Rinse off gently with water.
- Rinse with a wash of 1-3 teaspoons of vinegar in 1 quart of water. Do this rinse every 2-3 hours or more if you have more crusting. As you wash, the crusts become more hydrated and are more likely to fall off. Crusting can cause infections and scarring so it is important to hydrate them so they can fall off.
- Apply a light coat of Vaseline to cover the treated areas for 1-2 weeks until your skin has healed over and the peeling has finished.
- Never take off the peeling skin; it should fall off on its own.
- You can shower the day after but do not let the shower water directly hit your face because it can lead to the skin being peeled off forcefully and cause scarring.
- Start taking your antibiotics and continue antivirals until you finish them.
- Do not use any active or harsh products for at least 3 to 4 weeks after your treatment. The surface skin is brand new and needs to normalize.

First Night:

- Wash your face as above using gentle cleanser lather patted gently on the skin rinsing with cool water. Never rub or massage the treated area, as this could lead to scarring.
- Rinse with vinegar water solution to prevent infections and help healing.
- Apply Vaseline at all times for the first 1-2 weeks to help the skin heal.
- Place a towel over your pillow to protect from the Vaseline (occlusive ointment).
- Sleep on your back with your head slightly elevated; continue this every night until swelling subsides.
- If you experience eye irritation, use eye lubricant, such as Systane or Lacrilube before you go to sleep at night. You can also apply artificial tears every 30-60 minutes during the healing process for eye irritation.

Day 1 (First Day After Treatment):

- Stay indoors and avoid direct sunlight.
- Continue washing your face every 2-3 hours and more if you have more crusting with gentle cleanser lather patted gently on the skin rinsing with cool water. Never rub or massage the treated area, as this could lead to scarring.
- After cleansing apply the vinegar disinfectant solution.
- You can take a lukewarm shower and wash your hair, but do not let the water hit your treated area, which could force off the skin and lead to scarring.



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- Do not remove the flaking, peeling skin.
- Re-apply a light coat of Vaseline to the treated area after each cleaning.
- Drink lots of liquids and eat healthy foods. Avoid alcohol.
- Avoid exercising until your face is healed.
- You should avoid sun exposure as much as you can for the first 6 months.

Day 2:

- Continue washing your face up to 4 times a day and more if you have more crusting and rinsing with vinegar water solution to prevent infections and help healing.
- Apply Vaseline at all times for the first 1-2 weeks to help the skin heal.
- Itching, particularly along the jaw-line, tends to begin on this day. Hydrocortisone 1% OTC and oral Benadryl may reduce itching.
- Avoid picking or scratching, which could lead to scarring.

Day 3:

- Continue washing your face up to 4 times a day and more if you have more crusting and rinsing with vinegar water, and applying Vaseline.
- Itching may persist.
- The central area of the face will begin exfoliating today, leaving behind soft pink tissue.

Day 4 – 7:

- Itching has usually subsided.
- Continue your cleaning regime and continue applying the light coat of Vaseline.

Day 7:

- You can begin to transition from Vaseline to a non-occlusive gentle moisturizer but check with Dr Young before doing this.
- If you are ever unsure about your products, you can call the office to discuss your options.
- Continue your cleaning regime.

Day 10:

- If the treated area is healed, then you can start your regular skin care program but check with Dr. Young first, provided you do NOT use harsh, active, acidic products for up to 4 weeks after your treatment (do not use Prevenge, RetinA, hydroquinone etc.). After 4 weeks, check with Dr. Young to see if you can re-start the Tretinoin and Hydroquinone.
- Start applying a non-irritating sunscreen with titanium dioxide or parsol 1789 and apply mineral makeup to protect treated areas.



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- Avoid excessive sun exposure for the first 6 weeks – although avoiding sun for 6 months would be better, if possible. Hat and clothing can help protect treated areas.
- Slowly start your exercise program.

Weeks 2-4

- Continue to cleanse the skin gently with a Sensitive Skin Cleanser.
- Gently pat skin dry, never rub.
- Apply Skin Medica Dermal Repair Cream to entire face, day and night after cleansing.
- Every morning after applying Dermal Repair Cream, follow with Environmental Defense Sunscreen to protect the skin from damaging UVB and UVA sun rays.

Week 4

- Once the skin has healed over you may do a test spot with Epiquin and Retinol to see how your skin reacts. If there is no reaction you may start applying the topical medications as directed.
- If there is a reaction discontinue and try another test spot in one week.

Call Dr. Young at 425.990.3223, if you have any questions.



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Medications to Avoid

If you are taking any medications on this list, they should be discontinued 2 weeks before and after your procedure and only acetaminophen products, such as Tylenol, should be taken for pain. Most importantly we would like you to avoid high dose vitamin E (anything greater than 40IU), aspirin, anti-inflammatories, herbal medications, supplements (fish oil, omega 3's). All other medications – prescriptions, over-the-counter and herbal medications or supplements– that you are currently taking must be specifically cleared by Dr. prior to surgery. It is absolutely necessary that all of your current medications be specifically cleared by Dr. and the nursing staff.

Aspirin Medications to Avoid: *Affect blood clotting.*

4-Way Cold Tabs	Butalbital Compound	IBU	Panasal
5-Aminosalicylic Acid	Cama Arthritis Pain Reliever	Indomethacin products	Pentasa
Acetilsalicylic Acid	Carisoprodol Compound	Isollyl Improved	Pepto-Bismol
Actron	Cataflam	Kaodene	Percodan products
Adprin-B products	Cheracol	Lanorinal	Phenaphen/Codeine #3
Aleve	Choline Magnesium Trisalicylate	Ibuprohm	Pink Bismuth
Alka-Seltzer products	Choline Salicylate	Lodine	Piroxicam
Amigesic Argesic-SA	Cope	Lortab ASA	Propoxyphene Compound products
Anacin products	Coricidin	Magan	Robaxisal
Anexsia w/Codeine	Cortisone Medications	Magnaprin products	Rowasa
Arthra-G	Damason-P	Magnesium Salicylate	Roxeprin
Arthriten products	Darvon Compound-65	Magsal	Saleto products
Arthritis Foundation products	Darvon/ASA	Marnal	Salflex
Arthritis Pain Formula	Diclofenac	Marthritic	Salicylate products
Arthritis Strength BC Powder	Dipenturn	Mefenamic Acid	Salsalate
Arthropan	Disalcid	Meprobamate	Salsitab
ASA	Doan's products	Mesalamine	Scot-Tussin Original 5-Action
Asacol	Dolobid	Methocarbarnol	Sine-off
Ascriptin products	Dristan	Micrainin	Sinutab
Aspergum	Duragesic	Mobidin	Sodium Salicylate
Asprimox products	Easprin	Mobigesic	Sodol Compound
Axotal	Ecotrin products	Momentum	Soma Compound
Azdone	Empirin products	Mono-Gesic	St. Joseph Aspirin
Azulfidine products	Equagesic	Motrin products	Sulfasalazine
B-A-C	Etodolac	Naprelan	Supac
Backache Maximum Strength Relief	Excedrin products	Naproxen	Suprax
Bayer Products	Fiorgen PF	Night-Time Effervescent Cold	Synalgos-DC
BC Powder	Fiorinal products	Norgesic products	Talwin
Bismatrol products	Flurbiprofen	Norwich products	Triaminicin
Buffered Aspirin	Gelpirin	Olsalazine	Tricosal
Bufferin products	Genprin	Orphengesic products	Trilisate
Buffetts 11	Gensan	Orudis products	Tussanil DH
Buffex	Goody's Extra Strength	Oxycodonc	Tussirex products
Butal/ASA/Caff	Headache Powders	Pabalate products	Ursinus-Inlay
	Halfprin products	P-A-C	Vanquish
		Pain Reliever Tabs	



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Wesprin
Willow Bark products

Zorprin

Ibuprofen Medications to Avoid: *Affect blood clotting.*

Acular (ophthalmic)	Haltran	Nabumetone	Rhinocaps
Advil products	Indochron E-R	Nalfon products	Sine-Aid products
Anaprox products	Indocin products	Naprosyn products	Sulindac
Ansaid	Ketoprofen	Naprox X	Suprofen
Clinoril	Ketorolac	Nuprin	Tolectin products
Daypro	Ibuprin	Ocufen (ophthalmic)	Tolmetin
Dimetapp Sinus	Ibuprofen	Oruvail	Toradol
Dristan Sinus	Meclofenamate	Oxaprozin	Voltaren
Feldene	Meclomen	Ponstel	
Fenoprofen	Menadol	Profenal	
Genpril	Midol-products	Relafen	

Avoid ALL Diet Aids – Including Over-the-Counter & Herbal

Intensify anesthesia, serious cardiovascular effects.

Tricyclic Antidepressants to Avoid: *Intensify anesthesia, cardiovascular effects.*

Adapin	Doxepin	Maprotiline	Tofranil
Amitriptyline	Elavil	Norpramin	Triavil
Amoxapine	Endep	Nortriptyline	Trimipramine
Anafranil	Etrafon products	Pamelor	Vivactil
Asendin	Imipramine	Pertofrane	
Aventyl	Janimine	Protriptyline	
Clomipramine	Limbitrol products	Sinequan	
Desipramine	Ludiomil	Surmontil	

Other Medication to Avoid: *Affect blood clotting.*

4-Way w/ Codeine	Dicumerol	Miradon	Stelazine
A.C.A.	Dipyridamole	Opasal	Sulfinpyrazone
A-A Compound	Doxycycline	Pan-PAC	Tenuate
Accutrim	Emagrin	Pentoxifylline	Tenuate Dospan
Actifed	Enoxaparin injection	Persantine	Thorazine
Anexsia	Flagyl	Phenylpropanolamine	Ticlid
Anisindione	Fragmin injection	Prednisone	Ticlopidine
Anturane	Furadantin	Protarnine	Trental
Arthritis Bufferin	Garlic	Pyrroxate	Ursinus
BC Tablets	Heparin	Ru-Tuss	Virbamycin
Childrens Advil	Hydrocortisone	Salatin	Vitamin E
Clinoril C	Isollyl	Sinex	Warfarin
Contac	Lovenox injection	Sofarin	
Coumadin	Macrochantin	Soltice	
Dalteparin injection	Mellaril	Sparine	



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Salicylate Medications, Foods & Beverages to Avoid: *Affect blood clotting.*

Amigesic (salsalate)	Pabalate	Almonds	Garlic
Disalcid (salsalate)	Pepto-Bismol (bismuth subsalicylate)	Apples	Ginger
Doan's (magnesium salicylate)	Salflex (salsalate)	Apricots	Grapes
Dolobid (diflunisal)	Salsalate	Blackberries	Pickles
Magsal	Salsitab (salsalate)	Boysenberries	Prunes
Pamprin (Maximum Pain Relief)	Trilisate (choline salicylate + magnesium salicylate)	Cherries	Raspberries
Mobigesic		Chinese Black Beans	Strawberries
		Cucumbers	Tomatoes
		Currants	Wine

Vitamins and Herbs to Avoid

Affect blood clotting, affect blood sugar, increase or decrease the strength of anesthesia, rapid heartbeat, high blood pressure, liver damage. Note: Just because it is not of this list does not mean that it is safe to take while preparing for surgery.

Ackee fruit	Devil's club	Goldenseal	Muwort
Alfalfa	Dong Quai root	Gotu Kola	Nem seed oil
Aloe	Echinacea	Grape seed	Onions
Argimomy	Ephedra	Guarana	Papaya
Barley	Eucalyptus	Guayusa	Periwinkle
Bilberry	Fenugreek seeds	Hawthorn	Selenium
Bitter melon	Feverfew	Horse Chestnut	St. John's Wort
Burdock root	Fo-ti	Juniper	Valerian/Valerian Root
Carrot oil	Garlic	Kava Kava	"The natural Viagra®"
Cayenne	Ginger	Lavender	Vitamin E
Chamomile	Gingko	Lemon verbena	Willow bark
Chromium	Gingko biloba	Licorice root	Yellow root
Coriander	Ginseng	Ma Huang	Yohimbe
Dandelion root	Gmena	Melatonin	

If you are taking anything not on this list, please call the office at (425) 990-3223 to notify us and make sure that it is okay.



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PATIENT RIGHTS

The patient has the right to:

1. **Treatment without regard** to race, gender, age, national origin or cultural, economic, educational, or religious background, or the source of payment of his care.
2. Dignified, considerate and respectful care.
3. The **knowledge of the name of the surgeon** who has primary responsibility for coordination of his care and the names and professional relationships of other practitioners who will see him. All health care professionals practicing at the facility have had their credentials verified and have been approved to practice at the facility by the Governing Board.
4. **Receives information from his surgeon** about his illness, his course of treatment, and his prospects for recovery in terms that he can understand. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
5. **Receive the necessary information about any proposed treatment** or procedure in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of all the procedure(s) or treatment(s), the medically significant risk(s) involved in the treatment, an alternate course of treatment or non-treatment, and the risk(s) involved in each, including the name of the person who would carry out the treatment(s) or procedure(s).
6. **Participate actively in decision** regarding his medical care. To the extent it is permitted by law, this includes the right to refuse treatment.
7. **Full consideration of privacy** concerning his medical care program. Case discussion, consultation, examination and treatment are confidential and shall be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.
8. **Confidential treatment** of all communications and records pertaining to his care. His written permission shall be obtained before his medical records are made available to anyone not concerned with his care.
9. **Reasonable responses** to any reasonable request he makes for services.



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10. **Reasonable continuity of care** and to know, in advance the time and location of appointment(s), as well as, the practitioner providing the care.
11. **Be advised** if the surgeon proposes to engage in or **perform human experimentation** affecting his care or treatment. The patient has the right to refuse to participate in such research projects.
12. Be informed by his surgeon, or designee, of his **continuing health care requirements**.
13. Examine and receive an **explanation of his bill** regardless of the source of payment.
14. Have all **patients rights explained** to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient.
15. **Express any grievances** or suggestions verbally or in writing without fear of retribution or denial of care and expect his grievance to be reported to the person in charge immediately, and that his grievance will be investigated regarding treatment or care that is furnished, or fails to be furnished. **The patient has the right to contact AAAHC.org.**
16. Have information provided prior to 24 hours before the date of the procedure concerning the **policies on advanced medical directives concerning** such issues as living wills and durable powers of attorney that will be identified to the facility and followed as appropriate under State and Federal Regulations. **Document in a prominent part of the patient's current medical record whether or not the individual has executed an advance directive.**
17. Be informed of their **right to change primary or specialty physicians** if other qualified physicians are available.
18. Provided appropriate **information regarding malpractice insurance** coverage.
19. Patient will be **treated respectfully regarding** privacy, security, grievance resolution, spiritual care, and communication. If communication restrictions are necessary for patient care and safety, the facility must document and explain the restrictions to the patient and family.
20. Be **protected from abuse and neglect.**
21. Be **informed of unanticipated outcomes.**
22. **Aesthetic Facial Plastic Surgery is owned and operated by Dr. Young.**



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Aesthetic Facial Plastic Surgery, PLLC

INFORMED GENERAL CONSENT FORM AND AGREEMENT

INSTRUCTIONS

I hereby acknowledge that I have *carefully* and *completely* read the following informational packet regarding Aesthetic Facial Plastic Surgery, PLLC's ("AFPS") policies and guidelines for pre and post procedure activities and prohibitions. I have: (i) read; (2) understand; and (3) have had an opportunity to ask questions regarding each section of this form. You also understand that for each specific procedure, you will be required to sign additional consent forms addressing the specific risks, side effects, post-procedure care, etc., associated with those particular procedures you will be undergoing while under the care of Aesthetic Facial Plastic Surgery, PLLC. ("AFPS")

I certify that I have read the above Authorization and Release and fully understand its terms. If signing on behalf of a minor, I certify that am the parent, guardian, or conservator of the minor and I am authorized to sign this consent form on the minor's behalf.

Please Read the "Medications to Avoid" Sheet

It is known that aspirin, arthritis medicines, cold medicines, and other medicines containing aspirin and anti-inflammatories can cause prolonged and excessive bleeding during procedures. **Please stop taking aspirin, high dose vitamin E, herbal medications, supplements (like omega 3, fish oil), and anti-inflammatories (like Naproxen, Aleve, Ibuprofen, Advil, Indocin, Excedrin, Motrin, Piroxicam, etc) two (2) weeks before and after your procedure. If you have any questions or are medically required to take these products, please notify Dr Young.**

SECTION 1

INTRODUCTION TO AESTHETIC FACIAL PLASTIC SURGERY, PLLC

Aesthetic Facial Plastic Surgery, PLLC is a Professional Service Corporation which performs various plastic surgery procedures to enhance facial aesthetics of its patients.

These procedures can help the visible signs of aging, but cannot stop the process of aging. Since each individual is different, the risks and results of these procedures will vary from person to person. These procedures are performed under local, oral or conscious sedation and the results to the procedures you may undergo will vary. Some individuals may need extra healing time and may not be able to return to work or normal activities for a prolonged period of time.



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SECTION 2 ALTERNATIVES TO TREATMENT

Alternative forms of treatment consist simply not treating the face and neck region with these procedures. There are also surgical and nonsurgical methods for improving facial aesthetics and AFPS will provide you with the options that AFPS provides. You should have a thorough discussion with your treating physician on your options and alternatives.

SECTION 3 RISKS OF PROCEDURES

Every medical and surgical procedure involves a certain amount of risk and it is important that you understand these risks. An individual's choice to undergo a medical or surgical procedure is based on the comparison of the risk to potential benefit among other things. Although the majority of patients do not experience the following complications, you should discuss each of them with your physician to make sure you understand the risks, potential complications, and consequences of the associated procedures. Whenever the skin is cut or punctured it heals with a scar. Some procedures will result in a permanent scar.

Normal Symptoms that occur during the recovery periods: swelling and bruising, discomfort and some pain, crusting along the incision lines, numbness of operated upon skin lasting 3 months or possibly longer or permanent, itching, redness of scars.

With each individual procedure the consent to perform the procedure will outline in more detail some of the symptoms, side effects and risks.

SECTION 4 POST-PROCEDURE CARE

Post-procedure care is an important part of your plastic surgery experience. It is your obligation to make sure that you keep all your post-procedure appointments as directed and make sure that you promptly contact your Physician and seek emergency care in case of a medical emergency.



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SECTION 5 FINANCIAL POLICY REGARDING REVISION AND COMPLICATIONS

Every plastic and reconstructive surgeon has a few patients who will require revision or have some complications requiring additional surgery. As you have been or will be told, one cannot guarantee a result. In cosmetic procedures there are certain problems that will happen statistically no matter how good the care or how careful the doctor and team. Examples of problems that may be encountered are bleeding or an unfavorable scar after a surgical procedure. In both of these cases, it may be necessary to return the patient to surgery, either on an emergency basis (as in the case with bleeding) or an elective basis (as in the case of scarring).

We hope that no complication arises and no revisional surgery is necessary in your case. However, no plastic surgeon can guarantee this to all of his patients. It is important for the patient undergoing an elective surgical procedure to understand that surgical revision and complications may result in additional costs. If you have any questions regarding this policy, the office staff would be happy to discuss it with you.

SECTION 6 DEPOSIT/FEE

A **\$500** fee will be collected at the time you schedule your surgery or CO2 laser treatment. The **\$500** fee will be applied towards your surgery balance, which will be **collected in full** at the time of your pre-op appointment, which is scheduled 2 weeks prior to your surgery date. If you choose to cancel your surgery for any reason before your pre-op appointment, the **\$500** fee is still **non-refundable but is transferrable**.

If you decide to cancel or reschedule your surgery within 2 weeks from your procedure day for any reason except medical necessity, we will charge you 15% of your payment and can refund 85% of your payment or you can fully transfer the 85% of the remaining balance to another surgery day. If you cancel or reschedule less than 7 days before surgery, you will be charged \$300/hr (based on how much time was set aside for your procedure) and the remaining balance can be used for the next surgery day that you schedule. Should Dr. Young cancel your surgery for any reason, you are entitled to a full refund including your deposit if you cannot reschedule.

After your procedure, full refunds will not be given and any refund will be a credit toward future purposes and procedures, less Dr. Young's time prorated based on his hourly rate of \$1000/hr. It is important to discuss your expectations with your medical provider before the procedure. Our goal is to help you achieve the results you desire.



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Other treatments, including injectable or other laser treatments, must be paid in full on day of treatment.

There will be a \$35 return check fee for all returned checks.

If you have any questions regarding our financial or refund policy, feel free to ask our Patient Care Coordinator or Office Manager.

SECTION 7 DISCLAIMERS

I understand that AFPS will request or require me to sign the following consent forms: Patient HIPAA Consent Form, General Instruction Form, Photographic/Videographic Documentation Consent Form, Pain Management Agreement, Consent forms for each individual procedure I will undergo while under the care of AFPS.

Informed consent documents are used to communicate information about the proposed medical or surgical treatment along with disclosure of risks and alternative forms of treatment(s). The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances.

However, informed consent documents should not be considered all inclusive in defining other methods of care and risks encountered. Your physician may provide you with additional information, which is based on all the facts in your particular case and state of medical knowledge.

Informed consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of *all* the facts involved in individual case and are subject to change as science, knowledge, and technology advance and as practice patterns evolve.

For purposes of advancing medical education, I consent to the admittance of observers to the operating room.

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

I understand that the success of the procedure is to a great extent dependent upon my closely following pre-op and post-op instructions my doctor has provided to me. Post-op care, activities and precautions have been explained to me and I understand them fully.



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I also consent to the administration of such anesthetics as may be considered necessary and advisable by the attending physicians and/or anesthesiologist. I am aware that risks are involved with anesthesia, such as allergic or toxic reactions and even cardiac or respiratory arrest.

Your physician, and/or your physician's designees, reserve the right to discuss your case with any third parties if, in your physician's considered opinion, it becomes necessary to do so. Your signature below will indicate you consent to this reservation.

I have had sufficient opportunity to discuss this condition and treatment with the physician and/or your physician's associates, and all my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to give an informed consent to the proposed treatment.

Note: Since smokers have a higher rate of respiratory complications and delayed wound healing, smoking is not recommended for 2-3 weeks before or after the surgery.

I AM AWARE THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND ACKNOWLEDGE THAT NO GUARANTEES OR PROMISES HAVE BEEN MADE TO ME ABOUT THE RESULTS OF THE PROCEDURE.

I ALSO UNDERSTAND THAT MY RESULTS AND RECOVERY WILL VARY AND MAY NOT BE SIMILAR TO THE RESULTS AND RECOVERY OF THAT OF OTHER PATIENTS INCLUDING THOSE DEPICTED IN AESTHETIC FACIAL PLASTIC SURGERY, P.S ADVERTISING.

BE SURE TO ASK YOUR PHYSICIAN IF YOU HAVE ANY QUESTIONS ABOUT YOUR CARE OR PROCEDURE.

SECTION 8 MOTOR VEHICLE AND PROCEDURE DATE POLICY

It is the policy of this office to advise patients not to operate a motorized vehicle or power equipment on the day of surgery. The drugs administered during the procedure may impair driving ability and you should not drive when you are on any sedating medications such as sleeping pills, antihistamines, muscle relaxants, anti anxiety medications, Clonidine and pain medications. AFPS recommends that you have someone drive you to and from our facility if you are taking pain or sedation medications.



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I hereby release my Doctor from any and all actions, loss or injury sustained by me as a consequence of my operation of any motorized vehicle or equipment while under the influence of these sedating medications that are prescribed by him.

SECTION 9 SMOKING

NO SMOKING FOR AT LEAST TWO (2) WEEKS BEFORE AND AFTER YOUR PROCEDURE!!! I have been informed by AFPS that I am not to smoke for at least two (2) weeks before and after my scheduled procedure at AFPS.

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

****Consent to Be Signed Electronically As Part of the Medical Record****



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INFORMED CONSENT FOR CO₂ LASER SKIN RESURFACING

INSTRUCTIONS

This is an informed consent document that has been prepared to assist your plastic surgeon inform you concerning CO₂ Laser, its risks, and alternative treatment. It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent for surgery as proposed by your plastic surgeon and agreed upon by you.

GENERAL INFORMATION

The goal of CO₂ laser skin resurfacing surgery is to reduce or partially eliminate facial wrinkles or reduce scarring from skin conditions such as acne. Generally, the results of CO₂ laser skin resurfacing demonstrate improvement in the smoothness of the skin; however, a complete elimination of wrinkles or scarring is not a realistic expectation.

ALTERNATIVE TREATMENT

The alternatives to CO₂ laser skin resurfacing surgery include dermabrasion and other skin care alternatives. The advantages and disadvantages (risks and benefits) of each of these alternatives to CO₂ laser skin resurfacing surgery have been explained to me as well as the alternative of having no surgery, accepting my present skin condition, using cosmetics and considering other methods of skin rejuvenation surgery.

POSSIBLE INTRA-OPERATIVE COMPLICATIONS OF CO₂ LASER SKIN RESURFACING SURGERY

Blindness/Corneal Burns - There is a risk of accidental eye injury by the laser energy or beam, which could cause blindness or burns of the eyeball. This is unlikely since complete eye protection is provided at all times during the laser energy applications.

Flash Fires - Utilization of laser energy always raises the possibility of fire-related incidents. These are rare and are preventable by careful maintenance of the surgical equipment and stringent laser safety precautions.

POSSIBLE SHORT TERM EFFECTS OF CO₂ LASER SKIN RESURFACING

Pain - Discomfort, burning sensation or pain the first few days after surgery. A local anesthetic is usually used to block pain during the treatment, but some degree of discomfort will occur after the anesthetic effects have worn off and this pain may persist for several days.

Redness of Skin - Erythema or redness of the skin for a two- to six-month period or possibly longer.

Swelling - Temporary edema (swelling) or ecchymosis (bruising) of the tissue of the face and neck, usually subsiding in three to seven days.

Wound Healing - Oozing, weeping, crusting and flakiness of the treated area, usually persisting for one to four weeks.

Skin Thickening - Textural changes of the treated skin, such as skin thickening, which may persist for a variable time following the laser skin resurfacing treatment.

Cysts - Milia or cysts, especially in the eyelid skin region (if the eyelid skin is included in the area of treatment by the laser energy), particularly if ointments were used in the postoperative phase for a protracted period.

Skin Tightness - Sensation of skin tightness (peaks at 3-8 weeks postoperatively).



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Contact Dermatitis - Contact dermatitis due secondarily to topical preparations (ointments) used post-operatively.

Herpes Simplex Dermatitis (Fever Blisters) - Occurrence or recurrence of herpes simplex dermatitis, particularly if not pre-, intra- and post-operatively treated with a systemic antiviral medication such as Zovirax.

Skin Itchiness - Pruritis or itching in the early healing phase.

Skin Hyperpigmentation - Transient hyperpigmentation (darkening of the skin), especially in darker-skinned people, occurring three to eight weeks after laser therapy.

Cellulitis or Skin Infections - Cellulitis or infection of the skin and soft tissues, especially if careful post-operative hygiene is not practiced.

Skin Hypopigmentation - Hypopigmentation (lightening of the skin), which occurs because of laser-induced injury to the melanocytes (pigment containing cells in the skin) and which can be permanent.

POSSIBLE LONG TERM COMPLICATIONS OF CO₂ LASER SKIN RESURFACING SURGERY

Increased Susceptibility to Sun - Because of the permanent thinning of the epidermis and dermis and reduction in the number of melanocytes (pigment cells in the skin), there is probably a lifelong risk of greater susceptibility of CO₂ laser skin resurfaced areas to the photo-aging effects of sunlight and the carcinogenic (cancer-producing) effects of ultraviolet wavelengths inherent in sun exposure or the use of tanning devices. For these reasons, avoidance of sun exposure or protection against ultraviolet light damage to your skin by the use of sun-screening or sun-blocking lotions with SPF (sun-protective factor) of 30 or higher is strongly advised.

Scarring - The risk of scarring exists in all cases. It is variable and is often related to an individual's genetic makeup. Scarring can be reduced by carefully following appropriate aftercare instructions and notifying the physician if a problem develops.

Skin Pigment Changes - Skin color and texture changes may occur. At the junction of the treated and untreated areas, there may be a difference in color, texture and/or thickness of the skin.

Infection - Infection is a risk that occurs in any invasive or surgical procedure. It is minimized by proper surgical technique and proper post-operative care.

Ectropion - Cicatricial (scarring or shrinkage) ectropion (out-turning of the eyelid) and/or punctal (tear hole) eversion can occur, despite optimal surgical technique.

Blepharoptosis - Blepharoptosis (drooping of the eyelid) can result from inadvertent injury to structures in the upper eyelid, especially in thin-skinned people.

From a general standpoint; damage to organs, nerves, vessels, infection, anesthesia risks, death, blindness, poor results, bleeding, need for further procedures, fat atrophy (wasting), scarring are all rare possibilities.

I understand that exposure to the sun and excess heat must be avoided at all costs for a period of 6 months. No unprotected sun bathing is permitted for 6 months. To do so would encourage skin pigment changes and rhytids (wrinkles) necessitating further treatment.



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I understand this is an elective procedure and that CO₂ laser skin resurfacing surgery is not reversible. I also understand that more than one resurfacing procedure may be required to achieve the optimal obtainable results.

I understand the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results and procedure. It is not possible to state every complication that may occur as a result of CO₂ laser skin resurfacing surgery. Complications or a poor outcome may manifest weeks, months or even years after CO₂ laser skin resurfacing surgery.

My surgeon has explained CO₂ laser skin resurfacing surgery and its risks, benefits and alternatives and has answered all my questions about the CO₂ laser skin resurfacing surgical procedure. I therefore consent to having CO₂ laser skin resurfacing surgery.

ADDITIONAL ADVISORIES

Skin Disorders/Skin Cancer - Skin disorders and skin cancer may occur independently of CO₂ Laser.

Long-Term Results - Subsequent alterations in your skin may occur as the result of aging, weight loss or gain, sun exposure, pregnancy, menopause, or other circumstances not related to CO₂ Laser. Future surgery or other treatments may be necessary.

Female Patient Information - It is important to inform your plastic surgeon if you use birth control pills, estrogen replacement, or if you believe you may be pregnant. Many medications including antibiotics may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy.

Intimate Relations After Surgery - Surgery involves coagulating of blood vessels and increased activity of any kind may open these vessels leading to a bleed, or hematoma. Activity that increases your pulse or heart rate may cause additional bruising, swelling, and the need for return to surgery and control bleeding. It is wise to refrain from sexual activity until your physician states it is safe.

Smoking, Second-Hand Smoke Exposure, Nicotine Products (Patch, Gum, Nasal Spray) - Patients who are currently smoking, use tobacco products, or nicotine products (patch, gum, or nasal spray) are at a greater risk for significant surgical complications of skin dying, delayed healing, and additional scarring. Individuals exposed to second-hand smoke are also at potential risk for similar complications attributable to nicotine exposure. Additionally, smoking may have a significant 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 a significantly lower risk of this type of complication. Please indicate your current status regarding these items below:

_____ I am a non-smoker and do not use nicotine products. I understand the risk of second-hand smoke exposure causing surgical complications.

_____ I am a smoker or use tobacco / nicotine products. I understand the risk of surgical complications due to smoking or use of nicotine products.

It is important to refrain from smoking at least 6 weeks before surgery and until your physician states it is safe to return, if desired.



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Mental Health Disorders and Elective Surgery - It is important that all patients seeking to undergo elective surgery have realistic expectations that focus on improvement rather than perfection. Complications or less than satisfactory results are sometimes unavoidable, may require additional surgery and often are stressful. Please openly discuss with your surgeon, prior to surgery, any history that you may have of significant emotional depression or mental health disorders. Although many individuals may benefit psychologically from the results of elective surgery, effects on mental health cannot be accurately predicted.

Medications - There are many adverse reactions that occur as the result of taking over-the-counter, herbal, and/or prescription medications. Be sure to check with your physician about any drug interactions that may exist with medications which you are already taking. If you have an adverse reaction, stop the drugs immediately and call your plastic surgeon for further instructions. If the reaction is severe, go immediately to the nearest emergency room. When taking the prescribed pain medications after surgery, realize that they can affect your thought process and coordination. Do not drive, do not operate complex equipment, do not make any important decisions, and do not drink any alcohol while taking these medications. Be sure to take your prescribed medication only as directed.

PATIENT COMPLIANCE

Follow all physician instructions carefully; this is essential for the success of your outcome. It is important that the surgical incisions are not subjected to excessive force, swelling, abrasion, or motion during the time of healing. Personal and vocational activity needs to be restricted. Protective dressings and splints should not be removed unless instructed by your plastic surgeon. Successful post-operative function depends on both surgery and subsequent care. Physical activity that increases your pulse or heart rate may cause bruising, swelling, fluid accumulation and the need for return to surgery. It is wise to refrain from intimate physical activities after surgery until your physician states it is safe. It is important that you participate in follow-up care, return for aftercare, and promote your recovery after surgery.

HEALTH INSURANCE

Most health insurance companies exclude coverage for cosmetic surgical operations or any complications that might occur from cosmetic surgery. If the procedure corrects a breathing problem or marked deformity after a nasal fracture, a portion may be covered. **Many insurance plans exclude coverage for secondary or revisionary surgery.** Please carefully review your health insurance subscriber-information pamphlet.

FINANCIAL RESPONSIBILITIES

The cost of surgery involves several charges for the services provided. The total includes fees charged by your doctor, the cost of surgical supplies, anesthesia, laboratory tests, and possible outpatient hospital charges, depending on where the surgery is performed. Depending on whether the cost of surgery is covered by an insurance plan, you will be responsible for necessary co-payments, deductibles, and charges not covered. Additional costs may occur should complications develop from the surgery. Secondary surgery or hospital day surgery charges involved with revisionary surgery would also be your responsibility.

ADDITIONAL SURGERY NECESSARY

There are many variable conditions that may influence the long-term result from CO2 Laser. Secondary surgery may be necessary to obtain optimal results. Should complications occur, additional surgery or other treatments may be necessary. Even though risks and complications occur infrequently, the risks cited are particularly associated with CO2 Laser. Other complications and risks can occur but are even more uncommon. The practice of medicine and surgery is not an exact science. Although good results are expected, there is no guarantee or warranty expressed or implied, on the results that may be obtained. In some situations, it may not be possible to achieve optimal results with a single surgical procedure.



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DISCLAIMER

Informed-consent documents are used to communicate information about the proposed surgical treatment of a disease or condition along with disclosure of risks and alternative forms of treatment(s), including no surgery. The informed-consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances.

However, informed-consent documents should not be considered all inclusive in defining other methods of care and risks encountered. Your plastic surgeon may provide you with additional or different information which is based on all the facts in your particular case and the current state of medical knowledge.

Informed-consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

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



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CONSENT FOR SURGERY / PROCEDURE or TREATMENT

1. I hereby authorize Dr. Young and such assistants as may be selected to perform the following procedure or treatment: CO2 Laser Skin Resurfacing

I have received the following information sheet: Informed Consent - CO2 Laser

2. I recognize that during the course of the operation and medical treatment or anesthesia, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above physician and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician at the time the procedure is begun.
3. I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involve risk and the possibility of complications, injury, and sometimes death.
4. I acknowledge that no guarantee or representation has been given by anyone as to the results that may be obtained.
5. For purposes of advancing medical education, I consent to the admittance of observers to the operating room.
6. I consent to the disposal of any tissue, medical devices or body parts which may be removed.
7. I consent to the utilization of blood products should they be deemed necessary by my surgeon and/or his/her appointees, and I am aware that there are potential significant risks to my health with their utilization.
8. I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical-device registration, if applicable.
9. I understand that the surgeons' fees are separate from the anesthesia and hospital charges, and the fees are agreeable to me. If a secondary procedure is necessary, further expenditure will be required.
10. I realize that not having the operation is an option.
11. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
 - a. THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN
 - b. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
 - c. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-12). I AM SATISFIED WITH THE EXPLANATION.

****Consent Form to Be Signed Electronically as Part of the Medical Record****



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ANESTHESIA CONSENT FORM

INSTRUCTIONS

This is an informed consent document which has been prepared to help inform you about the anesthesia options available to you for your surgical procedure, their risks, as well as alternative treatment(s).

GENERAL INFORMATION

Washington State Law guarantees that you have both the *right* and the *obligation* to make decisions concerning your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team you must enter into the decision-making process. This form has been designed to acknowledge your acceptance of treatment recommended by your physician.

TYPES OF ANESTHESIA OFFERED

Please check the level of anesthesia you have chosen for your procedure, below:

Local Sedation

A local anesthetic agent such as Novocaine, Xylocaine, or Marcaine is introduced in to the tissue through injection and produces a numbness that allows surgery to be carried out with little to no discomfort while the patient is awake.

Oral Sedation

Local sedation is used in conjunction with Valium (sedative), Percocet (pain medication), and Phenergan (anti-nausea medication) which are ingested orally. You will experience little to no discomfort; be aware and conscious but fairly relaxed; and responsive to voice.

Conscious Sedation with Registered Nurse and Dr. Young

Versed or Fentanyl is administered through an intravenous line by our nurse. This level is a little deeper state of sedation. You will be very sleepy but still responsive to more forceful amounts of voice and touch. Some refer to this type of sedation as Twilight.

Conscious Sedation with a Certified Registered Nurse Anesthetist

The last type of anesthesia offered is administered through an intravenous line given by a Certified Registered Nurse Anesthetist. This level can allow you to go into a deeper state of conscious sedation where you require more stimulation through touch and voice to become responsive. With this level of sedation, you will be much less aware of what is going on during the procedure than the other levels.



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RISKS OF ANESTHESIA

I have been informed how each type of anesthesia is performed. I understand that all sedation and anesthesia medications involve risks of complications and serious possible damage to vital organs such as the brain, heart, lung, liver, and kidney, and that in some cases use of these medications may result in paralysis, cardiac arrest, and/or brain death from both known and unknown causes. I have been informed of possible alternative forms of treatment, including non-treatment.

I understand that, during the course of anesthesia, operation, post-operative care, medical treatment, or other procedure, unforeseen conditions may necessitate additional or different procedures than set forth above. I therefore authorize my above-named physician, and his/her assistants or designees, to perform such procedures that are considered necessary and desirable, in their professional judgment. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to my physician at the time the medical or surgical procedure is commenced.

I consent to the administration of sedation or anesthesia by my attending physician, by an anesthesiologist, or other qualified party under the direction of a physician as may be deemed necessary.

I hereby authorize Dr. Young and/or such associates or assistants as may be selected by said physician to administer anesthesia.

I certify that my physician has informed me of the nature and character of the proposed treatment, of the anticipated results of the proposed treatment, of the possible alternative forms of treatment, and of any recognized serious possible risks and complications of the proposed treatment and of alternative forms of treatment, including non-treatment.

<p>I CERTIFY THAT I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS, I HAVE HAD ALL ASPECTS OF THIS MEDICAL TREATMENT EXPLAINED TO MY SATISFACTION, AND I CONSENT.</p>
--

****Consent to be Signed Electronically as Part of the Medical Record****



AESTHETIC FACIAL PLASTIC SURGERY PLLC
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PAIN MANAGEMENT AGREEMENT

I understand that I have a right to comprehensive pain management along with the surgery that I will undergo. I wish to enter into a treatment agreement to prevent possible chemical dependency. I understand that failure to follow any of these agreed statements might result in Aesthetic Facial Plastic Surgery, PLLC ("AFPS") and Dr. Philip Young to not provide ongoing care for me.

I agree to undergo pain management by Aesthetic Facial Plastic Surgery, PLLC. Pain Management provided by AFPS is for the purpose of post-operative plastic surgery. I agree to the following statements:

- I will not accept any narcotic prescriptions from another doctor unless approved by all physicians.
- I will be responsible for making sure that I do not run out of my medications on weekends and holidays, because abrupt discontinuation of these medications will cause severe withdrawal syndrome.
- I will only take the medication as directed by AFPS.
- I understand that I must keep my medications in a safe place.
- I understand that AFPS will not supply additional refills for the prescriptions of medications that I may lose.
- If my medications are stolen, AFPS will refill the prescription one time only if a copy of the police report of the theft is submitted to the physician's office.
- I will not give my prescriptions to anyone else.
- I will only use one pharmacy.
- I will keep my scheduled appointments with AFPS unless I give notice of cancellation 24 hours in advance.
- I understand that pain medications can affect my breathing and could lead to life threatening situations if I am not careful. I understand that I should not take too much medication that I am too tired or drowsy that will lead me to stop breathing and result in death. I understand that I have a maximum amount that I can take in a 24 hour period but that some people respond differently and this maximum may be less than what is stated and that I need to see how the medication is affecting me.
- I understand that if there is any question or concern regarding taking pain medications or taking too much pain medication then I will contact Dr Young immediately or call 911.
- I agree to refrain from all mind/mood altering/illicit/addicting drugs including alcohol unless authorized by AFPS.



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My treatment plan may change based on outcome of treatment, especially if pain medications are ineffective. Such medications will be discontinued.

I understand that AFPS believes in the following "Pain Patients' Bill of Rights."

You have the right to:

- Have your pain prevented or controlled adequately.
- Have your pain and medication history taken.
- Have your pain questions answered.
- Know what medication, treatment or anesthesia will be given.
- Know the risks, benefits and side effects of treatment.
- Know what alternative pain treatments may be available.
- Ask for changes in treatments if your pain persists.
- Receive compassionate and sympathetic care.
- Receive pain medication on a timely basis.
- Refuse treatment without prejudice from your physician.
- Include your family in decision-making.

Termination Clauses

The doctor may terminate this agreement at any time if he/she has cause to believe that I am not complying with the terms of this agreement, or to believe that I have made a misrepresentation or false statement concerning my pain or my compliance with the terms of this agreement. Proof or verification of such beliefs is not required for termination and discontinuation of care.

I understand that I may terminate this agreement at any time.

If the agreement is terminated, I will not be a patient of AFPS or Dr. Philip Young and would strongly consider treatment for chemical dependency if clinically indicated.

Patient/Guardian Signature Date: _____

Print Patient/Guardian Name: _____

Physician Signature Date: _____

Print Physician Name: _____

****Consent Will Be Signed Electronically As Part of the Medical Record****



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PHOTOGRAPHIC / VIDEOGRAPHIC DOCUMENTATION CONSENT FORM

I hereby give my consent to the taking of photographs and/or video by Aesthetic Facial Plastic Surgery, PLLC ("AFPS") of me or parts of my body in connection with the procedure(s) to be performed by Dr. Philip Young for the sole purpose of internal use at AFPS.

I provide this authorization as a voluntary, yet private contribution: (i) for use in my medical files - patient chart - at AFPS; (ii) in the interests of Dr. Philip Young and office staff; (iii) for the purpose of facilitating consultations and procedural explanations to/for me; (iv) for AFPS training purposes. I understand that such photographs shall become the property of AFPS and may be retained by AFPS but **will not** be released by AFPS for any purposes such as print, visual or electronic media, medical journals and/or textbooks, or for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

I understand that I may be asked to sign a separate consent in the future for the purpose of releasing my photos for other uses such as advertising for the rights of AFPS, but will not be required to do so, and may refuse.

I understand that I may refuse to authorize the release of my photos for internal use and that my refusal to consent to the release will not affect the health care services I presently receive, or will receive, from AFPS.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it will not have any effect on any actions taken prior to my revocation.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I release and discharge AFPS, Dr. Philip Young, and all parties acting under the license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publications of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms. If signing on behalf of a minor, I certify that I am the parent, guardian, or conservator of the minor and I am authorized to sign this consent form on the minor's behalf.

****Consent Will Be Signed Electronically As Part of the Medical Record****



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CARETAKER CONSENT FORM

Your post-operative care is critical. Once you leave our office, your care will no longer be in our control and, therefore, you must have someone watching you carefully who can provide you the right doses of medicines. That is why Dr. Young recommends that you have 24 hour nursing care from a qualified nursing center. If instead you choose to have a family member or friend watch over you, then you must ensure that the person you select is qualified to take care of you during this critical state. Failure to have proper post-operative care may result in slowing your recovery, permanent damage and even death. Do not take the appointment of your caretaker lightly.

FOR PATIENT TO SIGN

I _____ (full name) appoint _____ (full name) as my post-operative caretaker for my surgery on _____ (date). I understand that Dr. Young recommends that I have qualified 24 hour nursing care, but I choose this person as my caretaker and accept the risk of my decision. I also understand that my private medical information will be disclosed to my caretaker as needed to help with my recovery. I also understand that any failure on the part of my caretaker does not create a liability to AFPS, which is not responsible for my choice in caretaker and his/her abilities. I remain solely responsible for my decision.

Patient Signature: _____ Date: _____

FOR CARETAKER TO SIGN

I _____ (full name) agree to care for _____ during the post-operative period of 24 hours or more as necessary after surgery on _____ (date). I do not take this obligation lightly and understand that I could be liable for failure to care for the patient properly. I will keep patient's medical information confidential and will not disclose said information to anyone except those people involved in patient's care. I agree to monitor the patient's vital signs by doing the following and keeping a record of my care:

- Staying in the same room as the patient;
- Making sure breathing is strong;
- Asking questions to make sure patient is able to respond;
- Making sure that the patient uses the restroom regularly;
- Giving liquids and food as directed;
- Giving the proper doses of medicine and recording patient's response.

If I have any question at all, I will call Dr. Young at 425 990 3223 or 206 353 0829. If there is any problem, I will immediately call 911 and Dr. Young at 425 990 3223.

I also understand that signing this form does not create a relationship between myself and AFPS; instead, my sole relationship is with the patient, who has chosen me to be the caretaker. Any failure on my part does not make AFPS liable in any way.

My phone numbers are: _____

Caretaker signature: _____ Date: _____



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PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, Pam, authorize Dr. Young and/or Aesthetic Facial Plastic Surgery, PLLC, and/or **[his/her/their]** representative(s), to take photographs, slides or videotapes of me or parts of my body for the following procedure(s) and for medical purposes to be used for my care, medical presentations and/or articles.

In addition, I authorize the use of these images, without compensation to me, for the following specific purposes: (Please **initial** in the boxes marked Yes or No for each item)

Yes	No	Medium
		in the office photo album for prospective patients.
		in office seminars for prospective patients.
		on our website for prospective patients.
		in print advertisements .
		on television .

Additional Comments:

I understand that:

1. Such photographs, slides or videotapes may be published by Dr. Young and/or Aesthetic Facial Plastic Surgery, PLLC in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods. I understand that such uses may also include marketing on behalf of Dr. Young, for which Dr. Young may be receive direct or indirect remuneration.
2. I will not be identified by name in any of the media described above; however, I also understand that in some circumstances the photographs, slides, or videotapes may display features that identify me.
3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to **[Privacy Officer/Responsible Person]** at 1810 116th Avenue NE A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization. If I do not revoke this authorization, it shall expire on the following date, event, or condition: **[Date/Event/Condition]**. If I fail to specify



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an expiration date, event, or condition, this authorization will expire in **[State Law Dictates - Months/Years]**, except to the extent action has been taken thereon.

4. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Young and/or Aesthetic Facial Plastic Surgery, PLLC.
5. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.
6. A copy of this Authorization is valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.

I release and discharge Dr. Young and/or Aesthetic Facial Plastic Surgery, PLLC from all liability, including liability for negligence, that in any way arises out of:

any and all rights that I may have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization; and

any claim that I may have or may have had relating to such use and disclosure of those photographs, slides or videotapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.

This Authorization is made as a voluntary contribution in the interest of public education and certify that I have read this Authorization and Release carefully and fully understand its terms.

If I have questions about the use or disclosure of my photographs, slides, or videotapes, I can contact **[Privacy Officer/Responsible Person]** at **[Phone Number]**.

Patient is a minor years of age, and we, the undersigned, are the parents or guardian of the patient and do hereby consent for the patient.

Signature _____ Date _____

Witness _____