AESTHETIC FACIAL PLASTIC SURGERY PLLC
DR. PHILIP YOUNG, MD

Aesthetic Facial Plastic Surgery, PLLC
1810 116th Ave NE #102
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GENERAL, HIPAA, PHOTO | VIDEO INFORMED CONSENT FORM, AND RELEASE AGREEMENT

Aesthetic Facial Plastic Surgery, PLLC's ("AFPS"), by and through Dr. Phillip Young, agree to provide treatment to: _____ ("Patient" or "you") [insert Patient's name] pursuant to terms and conditions set forth under this General Informed Consent Form and Release Agreement (the "Agreement") and such other consent or release AFPS may require from time to time.

Patient has received materials, literature and documents regarding AFPS's policies and guidelines for pre- and post-procedure activities and prohibitions, as well as medications to avoid and release of rights, including but not limited to the following:

1. Healing Body and Mind;
2. Your Anesthesia Experience;
3. Pre-Procedure Instructions;
4. Medications to Avoid;
5. Post-Procedure Instructions;
6. Post-Operative Instructions for Your Specific Procedure that you are receiving;
7. Patient Rights;
8. Anesthesia Consent Form;
9. Caretaker Consent Form;
10. Pain Management Consent Form; and
11. Photographic / Videographic Documentation Consent Form

By executing this Agreement, Patient certifies that he/she has: (i) read; (2) understood; and (3) had an opportunity to ask questions regarding each section of this Agreement and

all materials, literature and documents provided by AFPS. Patient understands that for each specific procedure, he/she will be required to sign additional consent forms addressing the specific risks, side effects, post-procedure care, etc., associated with those particular procedures Patient will undergo while under the care of AFPS. If the person signing as the "Patient" under this Agreement is doing so on behalf of a minor, then such person certifies that he or she is the parent, guardian, or conservator of the minor and that such person is authorized to sign this consent form on the minor's behalf.

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 to reduce the visible signs of aging, but cannot stop the process of aging. Since each individual's body is different, the risks and results of any medical procedure may vary from person to person. These procedures are generally performed under local, oral or conscious sedation and 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.

SECTION 2

ALTERNATIVES TO TREATMENT

There are surgical and nonsurgical methods for improving facial aesthetics and AFPS will provide you with options and alternatives that may be suitable for your objectives, which you should carefully review with your treating physician before deciding on one or more treatment procedures.

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, among other things, the comparison of the risk to potential benefit. Although the majority of patients do not experience complications, you should discuss each of them with your physician to make sure you understand the potential risks, 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 specific consent to perform the procedure will outline in more detail some of the symptoms, side effects and risks associated with such a procedure.

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. You must have a caretaker for the first 24 hours. **You should also record how you are taking your medications. You should record the date and time of each prescription drug you are taking, how much and what medications are given, and the total amounts of the drugs that are left each and every time.** Medications (especially pain medications) can be dangerous and you need to strictly follow the instructions on the prescription attached to the bottle.

SECTION 5

FINANCIAL POLICY REGARDING REVISION AND COMPLICATIONS

As you have been, or will be, advised, no plastic surgeon can guarantee a specific result. From time to time, some patients may require additional surgery to deal with revisions or complications. In cosmetic procedures, there are certain problems that are unavoidable regardless of quality of the care provided and diligence exercised by the doctor and his/her team.

Examples of problems that a patient may encounter include bleeding and/or an unfavorable scar after a surgical procedure. In both of these cases, the patient may require additional 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 revisionary surgery becomes necessary in your case. However, no plastic surgeon can make such a guarantee to any of his or her patients. It is important for the patient undergoing an elective surgical procedure to understand that surgical revisions and complications may result in additional costs. Revisions within six (6) months from the original procedure date will not incur additional physician fee; but facility, anesthesia and other fees and costs shall be the sole responsibility of the patient. Notwithstanding the foregoing, any revisions after six (6) months of the original procedure date will incur all standard fees and costs.

If you have any questions regarding this policy, our office staff would be happy to discuss it with you.

SECTION 6
DEPOSIT | FEE | CANCELLATION POLICY

Deposit | Fee for Surgical Procedures:

There are two choices with your Deposit: 1.) A non-refundable fee in the amount of five hundred dollars ($500) will be collected at the time you schedule your surgery or C02 laser treatment. This fee will be applied towards the total costs of your surgery, which shall be collected in full at the time of your pre-op appointment (two weeks prior to your surgery date). If you choose to cancel your surgery for any reason before your pre-op appointment, then the $500 fee will remain non-refundable but may be applied to future surgery/procedure or $250 of it can be applied to products, all within the next year from the time you place your deposit. 2.) A refundable fee of 20% that then becomes subject to the following that will apply to your full payment that is made 2 weeks before your procedure:

A. If you decide to cancel or reschedule your surgery within two (2) weeks of your surgery date, you will be responsible to pay thirty percent (30%) of the total costs of the procedure.

B. If you cancel or reschedule your surgery less than seven (7) days before the day of the procedure, you will be charged fifty percent (50%) of the total cost of the procedure.

C. After your procedure, there are no refunds given.

For non-surgical treatments, including injectable or other laser treatments, all fees and costs must be paid in full on day of treatment.

There will be a return check fee in the amount of thirty-five dollars ($35) 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.

Cancellation Policy for appointments | in-office procedures:

Injectibles (Botox | Dysport, Fillers): The no show fee for these appointments is **$100**.

Follow-ups, skin care treatments, consultations: The no show fee for these appointments is **$50**.

There is a 48-hour cancellation policy for all providers at AFPS for all appointments. If we are not informed of you cancellation before 48 hours before your appointment you will be charged the cancellation fee.

SECTION 7
DISCLAIMERS, RELEASES AND COVENANTS

Computer imaging may be used during your consultation. Although we strive to achieve the very best results every time, these images are used to help guide us during your procedure and are not a guarantee of results.

You understand that AFPS will request or require you to sign the following consent forms:

- Patient HIPAA Consent Form;
- General Instruction Form;
- Photographic/Videographic Documentation Consent Form;
- Pain Management Agreement;
- Caretaker Consent; and
- Consent forms for each individual procedure you 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 the 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 an individual case and are subject to change as science, knowledge, and technology advance and as practice patterns evolve.

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

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

You understand that the success of the procedure is to a great extent dependent upon your closely following Pre-Op and Post-Op instructions your doctor has provided to you. Post-Op care, activities and precautions have been explained to you and you understand them fully.

You also consent to the administration of such anesthetics as may be considered necessary and advisable by the attending physicians and/or anesthetist. You are 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 your consent to this reservation.

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

YOU ARE AWARE THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND ACKNOWLEDGE THAT NO GUARANTEES OR PROMISES HAVE BEEN MADE TO YOU ABOUT THE RESULTS OF THE PROCEDURE OR CARE PROVIDED BY AFPS. YOU UNDERSTAND THAT THE RESULT OF YOUR PROCEDURE AND RECOVERY WILL VARY AND MAY NOT BE SIMILAR TO THE RESULTS AND RECOVERY OF THAT OF OTHER PATIENTS, INCLUDING THOSE DEPICTED IN AFPS ADVERTISING. WITHOUT FOREGOING YOUR RIGHT TO PURSUE REMEDIES AT LAW OR IN EQUITY AS A RESULT OF AFPS'S NEGLIGENCE OR MALPRACTICE AND IN CONSIDERATION OF AFPS'S AGREEMENT TO PROVIDE TREATMENT, YOU HEREBY COVENANT THAT YOU WILL NOT WRITE, COMPOSE, PUBLISH, DISSEMINATE, MAKE, OR OTHERWISE DIRECT OR ENCOURAGE ANY THIRD PARTY TO DO SO, ANY NEGATIVE REVIEWS OR DISPARAGING REMARKS AGAINST AFPS OR DR. PHILLIP YOUNG, IN ANY MEDIUM OR FORUM WHATSOEVER (COLLECTIVELY "DISPARAGING REMARKS"). IF YOU MAKE ANY DISPARAGING REMARKS, THEN YOU EXCLUSIVELY ASSIGN ALL INTELLECTUAL PROPERTY RIGHTS, INCLUDING COPYRIGHTS, TO AFPS FOR ANY SUCH DISPARAGING REMARKS INCLUDING BUT NOT LIMITED TO WRITTEN, PICTORIAL, AND/OR ELECTRONIC COMMENTARY. THIS ASSIGNMENT SHALL BE OPERATIVE AND EFFECTIVE AT THE TIME OF YOUR CREATION (PRIOR TO PUBLICATION OR DISSEMINATION) OF THE DISPARAGING REMARKS.

SECTION 8

MOTOR VEHICLE AND PROCEDURE DATE POLICY

You are advised not to operate a motorized vehicle or power equipment on the day of surgery. The drugs administrated 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 the day of your procedure, if you are taking pain or sedation medications.

You hereby release and hold AFPS and Dr. Phillip Young harmless from any and all actions, loss or injury sustained by you or any third party as a consequence of your operation of any motorized vehicle or equipment while under the influence of sedating medications prescribed to you.

SECTION 9

SMOKING

NO SMOKING FOR AT LEAST TWO (2) WEEKS BEFORE AND AFTER YOUR PROCEDURE!!! You have been informed by AFPS that you are not to smoke for at least two (2) weeks before and after your scheduled procedure at AFPS. If you are unable to maintain this nonsmoking policy before the procedure, then you must notify AFPS immediately to reschedule your procedure date. If you are unable to maintain the nonsmoking policy after your procedure, then you must notify AFPS and your doctor immediately to assess your health risk and seek appropriate medical attention as necessary. You understand that this policy is in place for your health and safety and you shall not hold AFPS and Dr. Phillip Young responsible for any negative result which may have been directly or indirectly caused by smoking.

You hereby attest that you have read and understood the above information carefully and have had all your questions answered before signing the consent form.

SECTION 10

ADVANCED MEDICAL DIRECTIVE

You acknowledge that you have been informed that your Advanced Medical Directive will be suspended while you are being treated at AFPS. You have given a copy of your Advanced Medical Directive document to the staff at AFPS; in the event that it is necessary that you be transferred to a hospital for acute care, every effort will be made to assure that a copy of this document will accompany you. You understand that it is not the responsibility of AFPS to advise each care provider (emergency responders, emergency

room, acute care facility, etc.) of your Advanced Medical Directive and that you should keep a copy of your Advanced Medical Directive with you and your designated health care proxy should also maintain a copy of the form.

If no copy of the Advanced Medical Directive is supplied for your medical record, you release AFPS from any obligation or responsibility related to your status in this regard.

SECTION 11

CONSENT TO DRAW LABS FOR EXPOSURES

By signing this consent I also allow Aesthetic Facial Plastic Surgery and its Staff to carry out necessary blood work in the event of an accidental needle stick. The purpose of this is to allow Aesthetic Facial Plastic Surgery and its Staff to test your blood to see if you are a carrier of certain types of diseases including, but not limited to, Human Immunodeficiency Virus, Hepatitis, Syphillis, etc.

SECTION 12

Patient HIPPA Consent Form

Your health and health care information is both personal and private. Aesthetic Facial Plastic
Surgery, P.S. is dedicated to protecting your health care information. This HIPPA Consent Form
provides information about how Aesthetic Facial Plastic Surgery, P.S. may use and disclose your
Protected Health Information (PHI).

As part of your medical treatment, Aesthetic Facial Plastic Surgery, P.S. originates and maintains
paper and/or electronic records which contain PHI such as: demographic information; personal and family histories; symptoms; examination and test results; diagnoses; past, present and future plans for care and treatment; and information received from other health care providers, your employer and any health care plan. Aesthetic Facial Plastic Surgery, P.S. maintains Privacy Practices and Policies regarding the disclosure of PHI.

The Patient understands that:

- Protected Healthcare Information may be disclosed or used for treatment, billing and payment, or healthcare operations;
- The patient has the right and the opportunity to review Aesthetic Facial Plastic Surgery, P.S.'s

Privacy Practices and Policies;

- Aesthetic Facial Plastic Surgery, P.S. reserves the right to change it's Privacy Practices and
  Policies at any time;
- The Patient has the right to request, in writing, restricted disclosure of their PHI, however,
  Aesthetic Facial Plastic Surgery, P.S. is not bound by the restrictions unless an agreement
  regarding the requested restrictions has been reached;
- The Patient understand that they will be responsible for copying and mailing charges associated with sending their medical records.
- The patient may revoke their consent, in writing, at any time regarding all *future* disclosures.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or healthcare operations. You have a right to revoke this consent in writing, signed by you and delivered to our office. Revocation will apply to any future disclosures but not to any disclosure already made in reliance on your prior consent or as required by law. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Aesthetic Facial Plastic Surgery, P.S. reserves the right to change its Privacy Practices and Policies at any time. A revised copy of the Privacy Practices and Policies may be requested by contacting the office.

SECTION 13

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 the physician at AFPS 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 the physician 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, the physicians, 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