



AESTHETIC FACIAL BODY PLASTIC SURGERY
DR. PHILIP A. YOUNG, MD DR. RIKESH T. PARIKH, MD

BELOTERO | JUVEDERM | PERLANE | RESTYLANE INFORMED CONSENT

SECTION 1

INTRODUCTION TO BELOTERO | JUVEDERM | PERLANE | RESTYLANE

BELOTERO | JUVEDERM | PERLANE | RESTYLANE are sterile gels consisting of non-animal stabilized hyaluronic acid for injection into the skin to correct facial lines, wrinkles and folds in the United States and used to enhance the appearance & fullness of lips in over 60 other countries.

Hyaluronidase injections are used to take away BELOTERO | JUVEDERM | PERLANE | RESTYLANE and will be used sometimes to augment your results. Rarely, allergic reactions can occur with these injections, including the risks below that are similar to BELOTERO | JUVEDERM | PERLANE | RESTYLANE injections.

SECTION 2

RISKS OF PROCEDURES

Please review the following statements before signing this document as your acknowledgement and understanding of this consent form and the risks involved in this procedure.

- The details of the procedure have been explained to me in terms I understand.
- Alternative methods and their benefits and disadvantages have been explained to me.
- I am aware RESTYLANE | JUVEDERM | BELOTERO | PERLANE products are made from hyaluronic acid and are used as temporary filling agents for lines/wrinkles and to augment soft tissues of the face.
- I understand and accept the most likely risks and complications of BELOTERO | JUVEDERM | PERLANE | RESTYLANE injection(s) that include but are not limited to:

- Swelling and/or itching at injection site • Redness and/or bruising
- Facial Pain • Skin discoloration
- Scabbing around injection site • Tenderness at the implant site

These reactions typically resolve:

- Injection into the skin: Injection into the lips
- 2 to 3 days after treatment • Within a week after treatment



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- I understand and accept that other more rare reactions may occur with the use of BELOTERO | JUVEDERM | PERLANE | RESTYLANE injection(s) that include but are not limited to:

- swelling at the implant site (sometimes affecting surrounding tissue)
- Redness• Acne-like formations
- Permanent scarring at or around injection site
- Tenderness
- Extremely rare risks include damage to Organs, Nerves, Vessels, Infection, Death, Anesthesia Risks, Poor Results, Bleeding, Damage to Eye, Stroke, Blindness.

These reactions are rare (1 in 5,000 treated patients) and may occur one to several weeks after treatment. The average duration of these reactions are two (2) weeks.

- I am aware that the duration of the BELOTERO | JUVEDERM | PERLANE | RESTYLANE varies from patient to patient. Injections into the skin may last 6 months or longer while injections into the lips may last from 4 to 6 months.
- I am aware that follow-up treatments may help sustain the desired effect of the BELOTERO | JUVEDERM | PERLANE | RESTYLANE treatment.
- I am aware that smoking during the pre- and postoperative periods could increase chances of complications.
- I understand and accept the less common complications, including the remote risk of death or serious disability that exists with this procedure.
- I have informed the doctor of all my known allergies.
- I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies, and any other oral or topical treatments.
- I have been advised whether I should take any or all of these medications on the days surrounding the procedure.
- I am aware and accept that no guarantees about the results of the procedure have been made or implied.
- I have been informed of what to expect post-treatment, including but not limited to: estimated recovery time, anticipated activity level, and the necessity of additional procedures if I wish to maintain the appearance this procedure provides me.
- I am not currently pregnant or nursing and I understand that should I become pregnant while using this drug there are potential risks, including fetal malformation.
- If pre- and post-operative photos and/or videos are taken of the treatment for record purposes, I understand that these photos will be the property of Aesthetic Facial Plastic Surgery and may be used for used for medical, educational, scientific purposes and advertising purposes.
- I have had an opportunity to review and sign Aesthetic Facial Plastic Surgery's Photographic / Videographic Documentation Consent Form.
- The doctor has answered all of my questions regarding this procedure.
- I have been advised to seek immediate medical attention if swallowing, speech or respiratory disorders arise.

SECTION 3

POST-TREATMENT INSTRUCTIONS



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The following post-treatment procedures should be followed:

- Cold Compresses may be used immediately after treatment to reduce swelling. It is suggested to use a soft cloth dipped in cold water, wrung out, and applied to the injection area.
- Avoid touching the treated area within six hours following treatment to avoid injuring your skin. Afterwards, the area can be gently washed with soap and water.
- Avoid exposing the treated area to intense heat or UV lamp exposure until there is no redness or swelling.
- If you suffer from cold sores, there is a risk that the needle punctures could contribute to another recurrence. Speak to your physician about medications that may minimize a recurrence.
- Avoid taking aspirin, non-steroidal anti-inflammatory medications, St. John's Wart and high doses of Vitamin E supplements for one week after treatment. These may increase bruising and bleeding at the injection site.

SECTION 4

DISCLAIMERS

IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:

- A. THE ABOVE TREATMENT OR PROCEDURE TO 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. I AM SATISFIED WITH THE EXPLANATION.

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 PARTIENTS INCLUDED 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.

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

I authorize and direct Dr Philip Young, M.D., with associates or assistants of his or her choice, to perform the following procedure of BELOTERO | JUVEDERM | PERLANE | RESTYLANE injection(s) for the treatment of the proposed areas.



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I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature. 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.

I certify that I have explained the nature, purpose, benefits, risks, complications, and alternatives to the proposed procedure to the patient. I have answered all questions fully, and I believe that the patient fully understands what I have explained.



AESTHETIC FACIAL BODY PLASTIC SURGERY
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RADIESSE® INFORMED CONSENT

SECTION 1

INTRODUCTION TO RADIESSE®

Radiesse® is a stabilized calcium hydroxylapatite suspension for use in the cosmetic treatment of moderate to severe facial folds and wrinkles and has been used to augment the appearance of the lips. Radiesse® has been approved by the FDA for marketing for maxillofacial and vocal cord augmentation (“on label” use).

SECTION 2

RISKS OF PROCEDURES

Please review the following statements before signing this document as your acknowledgement and understanding of this consent form and the risks involved in this procedure.

- The details of the procedure have been explained to me in terms I understand.
- Alternative methods and their benefits and disadvantages have been explained to me.
- I am aware Radiesse® products are made from a stabilized calcium hydroxylapatite and are used as temporary filling agents for lines/wrinkles and to augment soft tissues of the face.
- I understand and accept the most likely risks and complications of Radiesse® injection(s) that include but are not limited to:

- Swelling and/or itching at injection site
- Redness and/or bruising
- Facial Pain
- Skin discoloration
- Scabbing around injection site
- Tenderness at the implant site

These reactions typically resolve within two (2) to three (3) days after treatment, however in some patients it may take weeks or months to resolve:

- I understand and accept that other more rare reactions may occur with the use of Radiesse® injection(s) that include but are not limited to:
 - swelling at the implant site (sometimes affecting surrounding tissue)
 - Acne-like formations
 - Redness
 - Keloid formation or hypertrophic scarring
 - Nodularity
 - Tenderness
 - Assymetry
 - Need for further corrective procedures
 - Vessel Formation
 - Damage to organs, nerves, vessels
 - Skin Loss



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- Blindness when injecting around the eyes
- Herpes Reactivation
- Poor Results

These reactions are rare (1 in 5,000 treated patients) and may occur one to several weeks after treatment. The average duration of these reactions are two (2) weeks.

- I am aware that the duration of the Radiesse[®] varies from patient to patient. Injections into the skin may last from 12 to 18 months.
- I am aware that I should not use Radiesse[®] if I have bad allergies, recently used drugs to thin my blood or to prevent clotting, or have a bleeding disorder.
- I am aware that follow-up treatments may help sustain the desired effect of the Radiesse[®] treatment.
- I am aware that smoking during the pre- and postoperative periods could increase chances of complications.
- I understand and accept the less common complications, including the remote risk of death or serious disability that exists with this procedure.
- I have informed the doctor of all my known allergies.
- I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies, and any other.
- I have been advised whether I should take any or all of these medications on the days surrounding the procedure. Including but not limited to, Aspirin, anti-inflammatory medications, all herbal medications and high doses of Vitamin E supplements will not be taken for two weeks before and after treatment. These may increase bruising and bleeding at the injection site.
- I am aware and accept that no guarantees about the results of the procedure have been made or implied.
- I have been informed of what to expect post-treatment, including but not limited to: estimated recovery time, anticipated activity level, and the necessity of additional procedures if I wish to maintain the appearance this procedure provides me.
- I am not currently pregnant or nursing and I understand that should I become pregnant while using this drug there are potential risks.
- If pre- and post-operative photos and/or videos are taken of the treatment for record purposes, I understand that these photos will be the property of Aesthetic Facial Plastic Surgery and may be used for used for medical, educational, scientific purposes and advertising purposes..
- I have had an opportunity to review and sign Aesthetic Facial Plastic Surgery's Photographic / Videographic Documentation Consent Form.
- The doctor has answered all of my questions regarding this procedure.
- I have been advised to seek immediate medical attention if swallowing, speech or respiratory disorders arise.

SECTION 3

POST-TREATMENT INSTRUCTIONS

The following post-treatment procedures should be followed:



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- Cold Compresses may be used immediately after treatment to reduce swelling. It is suggested to use a soft cloth dipped in cold water, wrung out, and applied to the injection area.
- Avoid touching the treated area within six hours following treatment to avoid injuring your skin. Afterwards, the area can be gently washed with soap and water.
- Avoid exposing the treated area to intense heat, UV Lamps, and bright sunlight until there is no redness or swelling.
- Avoid laser treatment, chemical peels, or other skin procedures until the skin has completely healed, otherwise there is a risk of an inflammatory reaction at the injection site.
- If you suffer from cold sores, there is a risk that the needle punctures could contribute to another recurrence. Speak to your physician about medications that many minimize a recurrence.
- Avoid taking aspirin, non-steroidal anti-inflammatory medications, all herbal medications and high doses of Vitamin E supplements for two weeks after treatment. These may increase bruising and bleeding at the injection site.
- No strenuous activity, hot liquids/foods, bending over, no massage in the procedural areas, no hot compresses, spicy foods, hot showers/bath (luke warm baths/showers are okay) for 1-2 weeks after the procedure.

SECTION 4

DISCLAIMERS

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- 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. I AM SATISFIED WITH THE EXPLANATION. I UNDERSTAND THE DISTINCTION BETWEEN “ON LABEL” AND “OFF LABEL” USE OF RADIESSE®. 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 PARTIENTS INCLUDED 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.

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

I authorize and direct Philip Young, M.D., with associates or assistants of his or her choice, to perform the following procedure of Radiesse® injection(s) for the improvement of the areas discussed.



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I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature. 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.

I certify that I have explained the nature, purpose, benefits, risks, complications, and alternatives to the proposed procedure to the patient. I have answered all questions fully, and I believe that the patient fully understands what I have explained.



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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 your Doctor prior to surgery. It is absolutely necessary that all of your current medications be specifically cleared by your Doctor and the nursing staff. **There are some foods that are listed below. We ask that you refrain from eating excessive amounts of the foods. A small amount is appropriate.**

Aspirin Medications to Avoid: *Affect blood clotting.*

4-Way Cold Tabs	Bayer Products	Duragesic	Marthritic
5-Aminosalicylic Acid	BC Powder	Easprin	Mefenamic Acid
Acetilsalicylic Acid	Bismatrol products	Ecotrin products	Meprobamate
Actron	Buffered Aspirin	Empirin products	Mesalamine
Adprin-B products	Bufferin products	Equagesic	Methocarbarnol
Aleve	Buffetts 11	Etodolac	Micrainin
Alka-Seltzer products	Buffex	Excedrin products	Mobidin
Amigesic Argesic-SA	Butal/ASA/Caff	Fiorgen PF	Mobigesic
Anacin products	Butalbital Compound	Fiorinal products	Momentum
Anexsia w/Codeine	Cama Arthritis Pain	Flurbiprofen	Mono-Gesic
Arthra-G	Reliever	Gelpirin	Motrin products
Arthriten products	Carisoprodol Compound	Genprin	Naprelan
Arthritis Foundation products	Cataflam	Gensan	Naproxen
Arthritis Pain Formula	Cheracol	Goody's Extra Strength	Night-Time Effervescent Cold
Arthritis Strength BC Powder	Choline Magnesium	Headache Powders	Norgesic products
Arthropan	Trisalicylate	Halfprin products	Norwich products
ASA	Choline Salicylate	IBU	Olsalazine
Asacol	Cope	Indomethacin products	Orphengesic products
Ascriptin products	Coricidin	Isollyl Improved	Orudis products
Aspergum	Cortisone Medications	Kaodene	Oxycodone
Asprimox products	Damason-P	Lanorinal	Pabalate products
Axotal	Darvon Compound-65	Ibuprohm	P-A-C
Azdone	Darvon/ASA	Lodine	Pain Reliever Tabs
Azulfidine products	Diclofenac	Lortab ASA	Panasal
B-A-C	Dipenturn	Magan	Pentasa
Backache Maximum Strength Relief	Disalcid	Magnaprin products	Pepto-Bismol
	Doan's products	Magnesium Salicylate	Percodan products
	Dolobid	Magsal	Phenaphen/Codeine #3
	Dristan	Marnal	



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Pink Bismuth	Salicylate products	Soma Compound	Trilisate
Piroxicam	Salsalate	St. Joseph Aspirin	Tussanil DH
Propoxyphene	Salsitab	Sulfasalazine	Tussirex products
Compound products	Scot-Tussin Original 5-	Supac	Ursinus-Inlay
Robaxisal	Action	Suprax	Vanquish
Rowasa	Sine-off	Synalgos-DC	Wesprin
Roxeprin	Sinutab	Talwin	Willow Bark products
Saleto products	Sodium Salicylate	Triaminicin	Zorprin
Salflex	Sodol Compound	Tricosal	

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.*



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4-Way w/ Codeine	Dicumerol	Miradon	Stelazine
A.C.A.	Dipyridamole	Opasal	Sulfipyrazone
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	Pyroxate	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	

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

(High concentration of foods to be avoided, you do not need to cut out these foods completely.)

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



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Post Procedure Instructions for Fillers (RADIESSE, BELOTERO | JUVEDERM | PERLANE | RESTYLANE)

Congratulations on having your filler placed! After the procedure, there can be swelling, bruising, lumps and bumps. These gradually decrease over the course of the week and usually improve a lot over the first three days. We usually suggest manual massage for the first 2 weeks over the areas that are more raised, noticeable or incongruent with the surrounding structures. If there are still some issues, you should make an appointment at 2 weeks and we can help resolve things for you. For RADIESSE, BELOTERO | JUVEDERM | PERLANE | RESTYLANE there are enzymes that can be injected to smooth away certain areas. Also, you can always inject more product to improve the appearance as well.

It is okay to put make-up on after your filler procedure but if you are particularly red it might be better to wait at least 1-2 days. It is always good to avoid high dose vitamin E, herbal medications, supplements (like fish oil, omega-3's), anti inflammatories (like naproxen, Aleve, ibuprofen, Indocin, piroxicam, sulindac, ecotrin, Bayer, aspirin, Motrin, Excedrin), and other blood thinners 2 weeks before and 2 weeks after your procedure. We have a list of medications and things not to take before your procedure on our resource page on our website. Avoiding blood thinners will help in preventing increased bleeding during and after your procedure. Excessive bleeding can create a lot of complications during your recovery and procedure.

Immediately after your procedure you should try your best to ice the areas of injection for 15min every hour. Icing is best the first 2-3 days. You can use ice but do not directly apply the ice to the skin. There should always be something in between the ice and your skin so you don't freeze or damage your skin. Plastic zip lock bags are great for this purpose. Frozen peas and cucumbers in a zip lock bag are a common recommendation. Commercially prepared icepacks are also very commonly prescribed.

For the first 48 hours it may be prudent to avoid hot showers (use luke warm water), hot and spicy liquids, foods. Try to keep things cool for the first 48 hours and limit your activity if possible. For the bruising you can alternate between warm and cold compresses but you should consult our Office before doing so.

If you have increased redness, swelling, or tenderness 2-3 days later this could indicate an infection and you should call us immediately at 425-990-3223 and possibly come in to see us. We will do everything we can to take care of you. We would like you to make a follow up appointment at 6 months for us to assess your progress. This is also the ideal time point to re-inject more product and get even longer lasting results based on scientific study. Please contact us anytime via email or calling us. We would like to be of any help during your journey towards facial rejuvenation.

Your Team at Aesthetic Facial Plastic Surgery



AESTHETIC FACIAL BODY PLASTIC SURGERY
DR. PHILIP A. YOUNG, MD DR. RIKESH T. PARIKH, MD

**Aesthetic Facial Body Plastic Surgery,
PLLC 1810 116th Ave NE #102
Bellevue, WA 98004**

GENERAL, HIPAA, PHOTO | VIDEO INFORMED CONSENT FORM, AND RELEASE AGREEMENT

Aesthetic Facial Body Plastic Surgery, PLLC's ("AFBPS"), 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 AFBPS may require from time to time.

Patient has received materials, literature and documents regarding AFBPS'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 AFBPS. 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 AFBPS. 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.



AESTHETIC FACIAL BODY PLASTIC SURGERY
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SECTION 1

INTRODUCTION TO AESTHETIC FACIAL BODY PLASTIC SURGERY, PLLC

Aesthetic Facial Body 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 AFBPS 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 | BOOKING FEE | CANCELLATION POLICY

Procedures:

Procedure quotes are valid for 3 months. To ensure you receive the procedure pricing, your procedure must be scheduled within 3 months and completed within 12 months of receipt of the original quote. Based on years of experience and to ensure an efficient schedule for the health of our office, a non-refundable deposit of 10% of the total cost of the procedure is required to reserve your procedure date. If you decide to reschedule or cancel your procedure you will be charged this deposit and it will be non-refundable and not applicable for future procedures. To reschedule to a different date you will be required to place another non-refundable deposit of 10% of the total cost of the procedure.

The total cost of your procedure will be collected in full at the time of your Pre-Operative appointment 2 weeks before your procedure date. If you cancel or reschedule your procedure within the 2 week time frame you will be charged 50% of the total cost of your procedure. After your procedure, there are no refunds given. If you have any questions regarding our financial or refund policy, feel free to contact our Patient Care Coordinator or Office Manager. You may make a payment by contacting our office at 425.990.3223 or through our [Plastic Surgery Financing and Online Payment page](#).

Appointments | in-office procedures:

A deposit of \$250 / \$500 (respectively) will be collected at the time of scheduling a Botox or Filler appointment with Dr. Young. If you decide to reschedule or cancel your procedure you will be charged this deposit and it will be non-refundable and not applicable for future procedures. To reschedule to a different date you will be required to place another non-refundable deposit. For Botox, Dr Young has a 40 unit minimum and a 2 syringe minimum for Fillers.

The remaining cost of your treatment will be collected in full at the time of your appointment. After your treatment appointment, there are no refunds given. If you have any questions regarding our financial or refund policy, feel free to contact our Patient Care Coordinator or Office Manager. You may make a payment by contacting our office at 425.990.3223 or through our [Financing and Online Payment page](#). The deposit and other fees can be paid on our Financing and Online Payment page or by contacting our office at 425.990.3223.

SECTION 7



AESTHETIC FACIAL BODY PLASTIC SURGERY
DR. PHILIP A. YOUNG, MD DR. RIKESH T. PARIKH, MD

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 AFBPS 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 AFBPS.

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.



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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 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. AFBPS 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 AFBPS 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 AFBPS that you are not to smoke for at least two (2) weeks before and after your scheduled procedure at AFBPS. If you are unable to maintain this nonsmoking policy before the procedure, then you must notify AFBPS immediately to reschedule your procedure date. If you are unable to maintain the nonsmoking policy after your procedure, then you must notify AFBPS 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 AFBPS 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 AFBPS. You have given a copy of your Advanced Medical Directive document to the staff at AFBPS; 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 AFBPS 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 AFBPS 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 Body 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 Body 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, Syphilis, etc.

SECTION 12



AESTHETIC FACIAL BODY PLASTIC SURGERY
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Patient HIPPA Consent Form

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

As part of your medical treatment, Aesthetic Facial Body 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 Body 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 Body Plastic Surgery, P.S.'s Privacy Practices and Policies;
- Aesthetic Facial Body 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 Body 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 Body 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 Body Plastic Surgery, PLLC ("AFBPS") of me or parts of my body in connection with the procedure(s) to be performed by the physician at AFBPS for the sole purpose of internal use at AFBPS.

I provide this authorization as a voluntary, yet private contribution: (i) for use in my medical files - patient chart - at AFBPS; (ii) in the interests of the physician and office staff;



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(iii) for the purpose of facilitating consultations and procedural explanations to/for me;
(iv) for AFBPS training purposes. I understand that such photographs shall become the property of AFBPS and may be retained by AFBPS but will not be released by AFBPS 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 AFBPS, 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 AFBPS.

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 AFBPS, 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****