**Orlando Plastic Surgery Institute**

Consent for E-mail

Orlando Plastic Surgery Institute offers our patients the opportunity to communicate by e-mail. This form provides information about the risks of e-mail, guidelines for e-mail communication and how we will use e-mail communication. It also will be used to document your consent for us to communicate with you by e-mail.

**RISKS**

Communication by e-mail has a number of risks which include, but are not limited to, the following:

o E-mail can be circulated, forwarded and stored in paper and electronic files.

o Backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy.

o E-mail can be received by unintended recipients.

o E-mail can be intercepted, altered, forwarded or used without authorization or detection.

o E-mail senders can easily type in the wrong e-mail address.

o E-mail can be used to introduce viruses into computer systems.

 **HOW WE WILL USE E-MAIL**

1. We will limit e-mail correspondence to established patients who are adults 18 years or older, or the legal representatives of established patients.
2. We will use e-mail to communicate with you only about non-sensitive and non-urgent issues such as:

o Questions about prescriptions, etc.

o Routine follow-up questions,

o Appointment scheduling, and/or

o Billing questions.

1. All e-mails to or from you may be made a part of your medical record. Your e-mail messages may be forwarded to another office staff member as necessary for appropriate handling.
2. We will not disclose your e-mail to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permit uses of your health information and your rights regarding privacy matters.

**IN A MEDICAL EMERGENCY, DO NOT USE E-MAIL…CALL 911.** Also, do not use e-mail for **urgent problems**. If you have an urgent problem, call our office 407-845-8280 or go to an urgent care facility.

**GUIDELINES FOR E-MAIL COMMUNICATION**

1. Include the general topic of the message in the “subject” line of your e-mail. For example, “advice,” “prescription,” “appointment” or “billing question.”
2. The e-mail message should not be time-sensitive. While we try to respond to e-mail messages daily, it may take up to three (3) working days for us to respond to your message. Urgent messages or needs should be relayed to us using regular telephone communication.
3. Include your name and phone number in the body of the message.
4. Review your message to make sure it is clear and that all relevant information is included before sending.
5. If your e-mail requires a response from us, and you have not heard back from us within three (3) working days, call our office to follow-up to determine if we received your e-mail.
6. Take precautions to protect the confidentiality of e-mail, such as safeguarding your computer password and using screen savers.
7. Inform us of changes in your email address.

**CONSENT**

I want Orlando Plastic Surgery Institute Providers and its office staff to communicate with me via e-mail.

1. I understand the risks of communicating by e-mail, in particular the privacy risks explained in this form. I understand that Orlando Plastic Surgery Institute cannot guarantee the security and confidentiality of e-mail communication. Orlando Plastic Surgery Institute will not be responsible for messages that are not received or delivered due to technical failure, or for disclosure of confidential information unless caused by intentional misconduct.
2. I understand that I may also communicate with Orlando Plastic Surgery Institute by telephone or during a scheduled appointment, and that e-mail is not a substitute for care that may be provided during an office visit. Appointments should be made to discuss any new issues or any sensitive medical information.
3. I understand that either I or Orlando Plastic Surgery Institute may stop using e-mail as a means of communication upon my written request.
4. I understand that I may revoke this consent at any time by so advising Orlando Plastic Surgery Institute in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for e-mail communications to and from Orlando Plastic Surgery Institute

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Orlando Plastic Surgery Institute**

HIPAA Policy Form

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information only to those that we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information (PHI), but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your PHI. If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Orlando Plastic Surgery Institute**

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize Orlando Plastic Surgery Institute to email my Treatment Records to the address below. I understand that email is not secure and could be intercepted and seen by others; in addition, I understand that there are other risks with email including misaddressed/misdirected messages; email accounts that are shared; messages forwarded to others; and messages stored on portable devices having no security. By choosing to receive my treatment records via email, I am acknowledging and accepting these risks.

Email Address Print Name

Signature Date

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**Orlando Plastic Surgery Institute**

Notice of Privacy Practices

**This Notice Describes How Health Information About You (As a Patient Of This Practice) May Be Used And Disclosed And How You Can Get Access To Your Individually Identifiable or Personal Health Information (PHI).**

This information is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Please Review This Notice Carefully**

**Our Commitment to your privacy:**

Our practice is dedicated to maintaining the privacy of your individually identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

**Our practice must provide you with the following important information:**

* How we may use and disclose your PHI
* Your privacy rights in your PHI
* Our obligations concerning the use and disclosure of your PHI

**We may use and disclose your PHI in the following ways:**

* Treatment: Our practice may use your PHI to treat you by providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may request laboratory tests and use the results to reach a diagnosis. We might use your PHI in order to write a prescription and might disclose your PHI to a pharmacy and access your PHI from other pharmacies.
* Payment: Our practice may disclose your PHI in order to obtain reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may contact your health insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if your insurer will cover your treatment.
* Health Care Operations: Our practice may use your PHI to operate our business, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service.
* Appointment Reminders: Our practice may use and disclose your PHI to contact you and remind you of an appointment.
* Electronic Transmission: Our practice may display the office name, address, and patient identifiable information on electronic transmission of insurance claims and statements.
* Release of Information to Family/Friends: Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you.

**Use and disclosure of you PHI in certain special circumstances:**

* For public health activities including reporting of certain communicable diseases.
* To authorities when we suspect abuse, neglect, or domestic violence.
* To health oversight agencies.
* For judicial and administrative proceedings pursuant to an administrative order.
* For law enforcement purposes.
* To avert a serious threat to your health and safety or that of others.
* For governmental purposes such as military service or for national security.
* In the event of an emergency or for disaster relief.
* For Worker’s Compensation or similar programs as required by law.
* Inclusive of any other instance required by law.

**Use and disclosure of you PHI in certain special circumstances:**

* For public health activities including reporting of certain communicable diseases.
* To authorities when we suspect abuse, neglect, or domestic violence.
* To health oversight agencies.
* For judicial and administrative proceedings pursuant to an administrative order.
* For law enforcement purposes.
* To avert a serious threat to your health and safety or that of others.
* For governmental purposes such as military service or for national security.
* In the event of an emergency or for disaster relief.
* For Worker’s Compensation or similar programs as required by law.
* Inclusive of any other instance required by law.

**Your rights regarding your PHI:**

* Confidential communications: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location.
* Requesting Restrictions: You have the right to request a restriction in our use of disclosure of your PHI treatment, payment or health care operations.
* Inspection of Copies: You have the right to inspect and obtain copy of the PHI that may be used to make decisions about you, including patient medical records and billing records.
* Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing providing a reason that supports your request.
* Accounting of Disclosures: All patients have the right to request an accounting of disclosures consisting of a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. For example, the provider sharing information with the medical assistant, or the billing department using information to file your insurance claim.
* Right to a Paper Copy of this Notice: You are entitled to receive a paper copy of our notice of privacy practices.
* Right to File a Complaint: If you believe your privacy rights have been violated, you may file a written complaint with our office, or with the Department of Health and Human Services, or the Office of Civil Rights.
* Right to Provide an Authorization for Other Uses and Disclosures: Our practice will obtain written authorization for uses and disclosures that are identified by this notice or permitted by applicable law.

Our practice is required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change terms of our Notice of Privacy practices and to make the new provisions effective for all protected health information that we maintain.

For more information about HIPAA or if you have any questions about this Notice, please contact: Dr. Anup Patel, HIPAA Privacy Officer, Orlando Plastic Surgery Institute, Inc., 801 N. Orange Avenue, #530, Orlando, Florida, Phone 407-845-8280.

**Receipt of Notice of Privacy Practices Written Acknowledgement Form**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have reviewed a copy of Orlando Plastic Surgery Institute, Inc.’s Notice of Privacy Practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Guardian Date

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**Orlando Plastic Surgery Institute**

Model Informed Consent

To the patient: You have the right to be informed about your skin condition and the treatment so that you may make an informed decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare, or alarm you, it is simply an effort to better inform you so that you may give or withhold your consent for the treatment.

1. I understand that the treatment I am about to undergo is for training purposes only.

**Initial if true:** \_\_\_\_\_\_\_\_

1. I understand that my decision to partake in this training is purely elective and that Orlando Plastic Surgery Institute, Dr. Anup Patel or staff has explained to me the nature and purpose of the course of treatment, administration and possible alternate methods of treatment, the expected benefits and complications, attendant discomforts and risk involved. I have been given the opportunity to ask questions and all of my questions have been fully and satisfactorily answered. I freely assume any known and unknown risks associated with this procedure. In the event that any unforeseen reaction should arise from this procedure, I will notify Orlando Plastic Surgery Institute immediately.

 **Initial:** \_\_\_\_\_\_\_\_

1. I understand that additional treatment may be required following this training exercise. I understand that payment for any additional treatment will be my responsibility.

**Initial:** \_\_\_\_\_\_\_\_

1. **Complimentary touch-ups are NOT included in this training exercise.** Any additional treatment that may be required following today’s training exercise will be my financial responsibility at Orlando Plastic Surgery Institute’s normal pricing structure (below).

|  |  |
| --- | --- |
| Botox: $600 for full facial treatment | Restylane-L: $900 (1mL) |
| Juvederm Ultra XC: $900 (1mL) | Perlane-L: $900 (1mL) |
| Juvederm Ultra Plus: $900 (1mL) | Belotero: $575 |
| Juvederm Vollure: $1000 (1mL) | Radiesse: $500 (.8cc), $900 (1.5cc) |

 **Initial:** \_\_\_\_\_\_\_\_

1. I agree to adhere to all safety precautions and regulations during the treatment. I am aware and will follow post procedure instructions such as; staying in an upright position for 4 hours following the treatment and abstaining from alcohol and strenuous exercise for the next 6 hours.

**Initial:** \_\_\_\_\_\_\_\_

1. **PAYMENT**: This procedure is cosmetic in nature and non-refundable; I understand that payment will be my responsibility.

**Initial:** \_\_\_\_\_\_\_

1. **Arbitration** **Agreement** – Patient consents that any controversy between Orlando Plastic Surgery Institute and the patient shall be settled by arbitration in accordance with the then-current commercial arbitration rules of the American Arbitration Association, and judgment on the award rendered by the arbitrator(s) may be rendered by any court having jurisdiction thereof. Orlando Plastic Surgery Institute and patient shall share the costs of the arbitrator equally but shall each bear their own costs and legal fees associated with the arbitration. The location of the arbitration shall be in Orlando, Florida. **Initial:** \_\_\_\_\_\_\_\_

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion and to ask questions.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Orlando Plastic Surgery Institute**

Cancellation Policy

Unanticipated events happen...it is a fact of life. Recognizing this, and in an effort to be fair to all of our valued clients, the following policy has been put into place.

**24 hour advance notice is required when cancelling or rescheduling an appointment.**

**Cancellations & Rescheduling:** This policy gives other clients the opportunity to schedule an appointment. If you are unable to provide at least 24 hours advance notice, you will be charged $50. This amount must be paid prior to your next scheduled appointment.

**No-Shows:** Anyone who either forgets or consciously chooses to forgo their appointment for any reason will be considered a "No-Show," and will be charged $50 for their missed appointment.

**Late Arrivals:** If you arrive late, your session may need to be shortened in order to accommodate on-time clients. Your provider will determine if there is enough time remaining to start a treatment.

PAYMENT POLICY

It is Orlando Plastic Surgery Institute, Inc's policy that payment is the responsibility of the patient at the time of service.

**Orlando Plastic Surgery Institute is pleased to accept the following forms of payment at time of service**

* Patient's credit card with photo ID
* Second party credit card with a copy of the cardholder's photo ID and signed note from cardholder authorizing charges to be made by Orlando Plastic Surgery Institute.
* Orlando Plastic Surgery Institute discount offers and coupons MAY be combined with manufacturer discounts and promotions, up to ONE Orlando Plastic Surgery Institute promotion may be redeemed per visit.
* Orlando Plastic Surgery Institute gift certificates.

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Orlando Plastic Surgery Institute**

Compliance Assurance Notification For Our Patients

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the “Privacy Rule”. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our valued patients.

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 **Orlando Plastic Surgery Institute**

Release and Consent to Photograph

The undersigned herby authorizes Orlando Plastic Surgery Institute to photograph (print patient name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_who is under the care of Orlando Plastic Surgery Institute.

**Scope of Consent**. The undersigned agrees that Orlando Plastic Surgery Institute may use the photograph(s) for any and all purposes including, but not limited to, art, advertising, promotional, educational and medical office books and presentations used for patient decision-making and in all media, including electronic, digital and print media and that such distribution may be accomplished in any manner.

**Term**. This release and consent shall remain in effect until rescinded in according with the following "Notice and Termination Use" provision below, and some use may continue after that time, but only as provided in the "Notice and Termination of Use."

**Notice and Termination of Use**. This release and consent may be rescinded at any time in accordance with the terms of this "Notice and Termination of Use" provision. Rescission of this consent must be in writing, requesting discontinuation of use of photographs taken while under the care of Orlando Plastic Surgery Institute. After receiving the written request, Orlando Plastic Surgery Institute may continue using the photographs until the existing inventory is depleted, or for television commercials, videos or similar materials, may continue using the photographs until as long as they were intended to be used at the time they were created. Orlando Plastic Surgery Institute will not reprint existing materials or create new advertising or other materials incorporating the photographs unless otherwise allowed to do so under this "Notice and Termination of Use" provision.

**Waiver**. Except as specifically stated above, I hereby waive any and all other rights I may have with respect to any photographs taken of me by Orlando Plastic Surgery Institute and all images created from them in accordance with the release and consent. Without limiting the generality of the foregoing, I specifically waive (i) any rights I may have had to be paid or otherwise compensated for the use of such photographs, and (ii) any rights I may have to inspect or approve the finished photographs, images, or printed matter that may be used in conjunction with any photographs taken of me.

**Entire Agreement**. This release and consents constitutes the sole agreement between Orlando Plastic Surgery Institute and myself regarding my photographs and I am not relying on any other oral or written representations made by Orlando Plastic Surgery Institute.

**Release**. The undersigned hereby releases and holds Orlando Plastic Surgery Institute harmless from and against any claim or injury or compensation resulting from the activities authorized by this release and consent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print) Patient Name Patient Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date

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**Orlando Plastic Surgery Institute**

INFORMED BOTOX/DYSPORT/XEOMIN INJECTION CONSENT

To the patient: You have the right to be informed about your skin condition and the treatment so that you may make an informed decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare, or alarm you, it is simply an effort to better inform you so that you may give or withhold your consent for the treatment.

1. I authorize the injection listed above, to my face and/or lips. I hereby consent to Orlando Plastic Surgery Institute, Dr. Anup Patel and members of the staff to perform multiple BOTOX/DYSPORT/XEOMIN and related services to me in the judgment of Dr. Anup Patel and members of his staff. For the purpose of chemical denervation for the treatment of one or more of the following; tension headaches, migraine headaches, wrinkle reduction or excessive sweating. I understand that in rendering treatment to me, Orlando Plastic Surgery Institute and Dr. Anup Patel will exercise his best skills and judgment as a medical professional but does not warrant and guarantee with respect to the results of this procedure. **Initial if true:** \_\_\_\_\_\_\_\_
2. Side effects may include: dry mouth, discomfort or pain at the injection site, bruising (that may persist for several weeks), tiredness, headache, neck pain, double vision, blurred vision, decreased eyesight, dry eyes, drooping eyelids, swelling of the face or eyelids, flu- like symptoms, respiratory infection, nausea, muscle weakness, and swallowing or breathing difficulties. In the event that any unforeseen reaction should arise from this procedure, I will notify my MD or NP immediately. **Initial:** \_\_\_\_\_\_\_\_
3. I understand that Botox/Dysport/Xeomin can spread or migrate from the intended injection site which may cause undesirable results. **Initial:** \_\_\_\_\_\_\_\_
4. Botox/Dysport/Xeomin is a product that has been on the market worldwide. It typically lasts 3 to 4 months however each patient responds differently to Botox/Dysport/Xeomin. No guarantee can be made with regard to the result or length of time it will last. **Initial:** \_\_\_\_\_\_\_\_
5. The above points, among others, have been specifically made clear. I understand that this procedure is purely elective and Orlando Plastic Surgery Institute, Dr. Anup Patel or staff has explained to me the nature and purpose of the course of treatment, administration and possible alternate methods of treatment, the expected benefits and complications, attendant discomforts and risk involved. I have been given the opportunity to ask questions and all of my questions have been fully and satisfactorily answered. I freely assume any known and unknown risks associated with this procedure. **Initial if true:** \_\_\_\_\_\_\_\_
6. I agree to adhere to all safety precautions and regulations during the treatment. I am aware and will follow post procedure instructions such as; staying in an upright position for 4 hours following the treatment and abstaining from alcohol and strenuous exercise for the next 6 hours. **Initial:** \_\_\_\_\_\_\_\_
7. **PAYMENT**: This procedure is cosmetic in nature and non refundable; I understand that payment will be my responsibility.

 **Initial:** \_\_\_\_\_\_\_\_

1. **Arbitration** **Agreement** – Patient consents that any controversy between Orlando Plastic Surgery Institute and the patient shall be settled by arbitration in accordance with the then-current commercial arbitration rules of the American Arbitration Association, and judgment on the award rendered by the arbitrator(s) may be rendered by any court having jurisdiction thereof. Orlando Plastic Surgery Institute and patient shall share the costs of the arbitrator equally but shall each bear their own costs and legal fees associated with the arbitration. The location of the arbitration shall be in Orlando, Florida. **Initial:** \_\_\_\_\_\_\_\_

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion and to ask questions.

Patient’s Signature: Date:

Clinician Signature: Date:

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**Orlando Plastic Surgery Institute**

Dermal Fillers Information and Consent Sheet

|  |  |
| --- | --- |
| **Benefits** | **Risks** |
| Fills in lines and creases | Bruising, redness and swelling |
| Plumps up sunken areas of the face | Allergic reaction |
| Adds fullness to lips and cheeks | Infection |
| Fills in depressed scars | Scarring |
| Minimal downtime | Only slight improvement |
|  | Unknown complications |
|  | Vascular Compromise |

In order to minimize complications, please follow all post procedural instructions. Some dermal filler material is not yet FDA approved for lip augmentation or peri-orbital depression. Long-term effects are unknowns.

Certain dermal fillers require an allergy test before injections. Allergic reactions are classified as prolonged redness, swelling, itching and firmness at some of the sites. A rare reaction is the development of a cyst-like reaction that may be drained and can cause a scar. Duration of allergic reactions may last up to 24 months. People with histories of atopic or allergic reactions to other substances may take special care when receiving injections. Systemic complaints have been reported in fewer than five per one thousand treated and included flu-like symptoms and possible ananphylactoid reactions.

**Before the procedure:**

* Avoid fish oil, Vit E, Asprin, Ibuprofen and Aleve for 10 days prior to the injections and 5 days post.
* Prior to temporarily discontinuing any medications, such as blood thinners, please consult your prescribing physician.
* Do not drink alcoholic beverages for 48 hours prior to the procedure.
* Prescribed medications may be taken the morning of the procedure with a light breakfast.

**After the procedure:**

* Pain medication: Tylenol or ibuprofen should suffice for pain.
* Diet: Meals are not restricted.
* Makeup: Do not apply makeup to the treated area for 24 hours after the treatment as this will increase the chance of scarring.
* Rest: try to rest for 12-24 hours.
* Bathing: Normal showering is permitted the day after the procedure.
* Head elevation: Keep your head elevated for the remainder of the day. Sleep on your back with several pillows the first night.
* Avoid sun tanning until the bruising has subsided.
* Mild swelling and bruising may occur for the first couple of days post-procedure. The filler may be palpable and feel temporarily firm for the first week.
* Please contact our office with all additional questions.

**Patient: Date:**

**Permission**: I hereby consent to authorize Orlando Plastic Surgery Institute and Dr. Anup Patel, or other staff to perform multiple injections and any related services on me, in the judgment of the clinician, for the purpose of tissue expansion for the correction of one or more of the following: depressed scars, wrinkles, lip augmentation, and or facial contouring. I understand and acknowledge that in rendering treatment to me, the clinical staff at Orlando Plastic Surgery Institute, Inc. will exercise their best skills and judgment as a health care practitioner.

I consent to be treated with one or more of the following dermal fillers: Belotero, Juvederm Ultra XC, Juvederm Ultra Plus XC, Juvederm Voluma, Restylane-Lift, Restylane-L, Restylane Silk

**Unforeseen Conditions:** If any unforeseen condition arises in the course of this treatment, which requires, in the judgment of the clinical staff, an additional procedure, I further request and authorize the carrying out of such procedures. In such cases, I will be responsible for any additional costs. In the event of an unforeseen reaction or condition I will immediately contact Orlando Plastic Surgery Institute, Inc.

**Anesthesia:** I consent to the administration of anesthesia in the form of lidocaine injections and or any other form deemed appropriate by the best judgment of clinical staff. I understand that there are certain risks and complications, which may result from the administration of this anesthesia, and I freely assume these risks.

**Explanation of Procedure, Risks, Benefits and Alternatives:** I understand that this procedure is purely elective and the clinical staff at Orlando Plastic Surgery Institute, Inc. have fully explained the nature and purpose of this treatment and administration of injections, possible alternate methods of treatment, the expected benefits and complications, attendant discomforts nd risks involved. I understand that, like other medical treatments, there are certain known and unknown risks, and I freely assume these risks. I have been given information on Dermal Fillers and have been given adequate time to read and discuss this information. **I understand that the FDA has approved this procedure for certain medical conditions, which may or may not be the specific procedure that I am requesting.** I freely assume all the known and unknown risks associated with this procedure. Although rare, these risks may include, but are not limited to swelling, scars, unfavorable cosmetic results, no results, nerve damage, infection, chronic problems, even death.

**No Guarantees:** I acknowledge that although these treatments are effective in most cases, no guarantee or assurance has been made to me as to the result that may be obtained. I am aware that follow-up treatments may be necessary to obtain results at additional costs to me.

**Photographs:** I agree to have pictures taken of my treatment site. However, my name and identity will not be disclosed to any third party except in a court of law in the event of a legal dispute.

**Payment:** I agree to the terms and conditions of the payment and pay the fee as agreed upon in the pre-treatment consultation. I understand this procedure is cosmetic in nature and non-refundable.

**Safety:** I agree to adhere to all safety precautions and regulations during the treatment.

**Arbitration** **Agreement**: Patient consents that any controversy between Orlando Plastic Surgery Institute and the patient shall be settled by arbitration in accordance with the then-current commercial arbitration rules of the American Arbitration Association, and judgment on the award rendered by the arbitrator(s) may be rendered by any court having jurisdiction thereof. Orlando Plastic Surgery Institute and patient shall share the costs of the arbitrator equally but shall each bear their own costs and legal fees associated with the arbitration. The location of the arbitration shall be in Orlando, Florida..

 **Initial:**

I certify that I have read and fully understand the above terms and conditions, and consent to the procedure that has been explained to me herein and in the accompanying literature. I also certify that all blank spaces above have been completed prior to my signing, and that I am over the age if eighteen, and competent to give this consent. This consent form supersedes all previous verbal or written communications given to me by Orlando Plastic Surgery Institute, Inc. This consent form is valid unless all or part is revoked by me in writing.

Patient’s Signature: Date:

Clinician Signature: Date:

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**Orlando Plastic Surgery Institute**

INFORMED CHEMICAL PEEL CONSENT

1. I hereby authorize the chemical peel procedure recommended, to be applied to my face and/or neck, chest and hands.
2. Depending on the chemical peel site, there may be redness and/or irritation and discoloration (dark tan or pink marks) that can persist for several days or weeks.
3. Occasionally, hyper-pigmentation or hypo-pigmentation may develop after the peel that can persist for weeks or months.
4. With each chemical peel results are achieved. Nonetheless, no guarantees can be made to the final results. Any number of chemical peels may be required to achieve desired results, depending on the present skin condition, skin care maintenance program, age and lifestyle of the patient.
5. Once the desired results are achieved, I understand that maintenance peels are necessary to sustain the results. The frequency depends on the individual’s own genetics, age and lifestyle.
6. Once the peeling process is complete, it is essential to follow all post-care instructions and come in for a mandatory 10 day follow-up.
7. These services are cosmetic in nature, and are non refundable. I understand that payment is my sole responsibility.
8. **No guarantee can be made that the skin will physically flake or peel**. **Initial:**
9. **Arbitration** **Agreement** – Patient consents that any controversy between Orlando Plastic Surgery Institute and the patient shall be settled by arbitration in accordance with the then-current commercial arbitration rules of the American Arbitration Association, and judgment on the award rendered by the arbitrator(s) may be rendered by any court having jurisdiction thereof. Orlando Plastic Surgery Institute and patient shall share the costs of the arbitrator equally but shall each bear their own costs and legal fees associated with the arbitration. The location of the arbitration shall be in Orlando, Florida.

Patient’s Signature: Date:

Clinician Signature: Date:

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**Orlando Plastic Surgery Institute**

INFORMED CHEMICAL PEEL CONSENT

Chemical Peeling is a “skin cell loosening” technique. Skin is supposed to shed and renew itself every 28 days. However, due to genetics and age, this differs in some people and as time goes on the process drastically slows down. A chemical peel is simply an accelerated form of skin exfoliation resulting in newer, smoother skin.

Although the name may sound frightening, don’t be scared- there are many types of chemical peels, varying in strength. There are varying degrees of depth of a peel, ranging from a very light superficial exfoliation (removing dead skin cells and requiring no downtime) to a medium or deeper peel (removing more layers for a deeper resurfacing and refinement of the skin with a moderate amount of downtime).

A chemical peel is used to help “dry out” active acne (loosening deep impactions making them easier to extract), to help reduce shallow wrinkling and scarring, to help lighten hyperpigmentation (dark spots on the skin), and to help improve the overall appearance and health of aging skin. Clearing depends on diligence to both home care and regularity of treatments. Clearing is also determined by how well instructions are followed.

NOTE: There are no guarantees as to how much the skin will peel.

**By signing this form, I hereby authorize the chemical peel procedure, should it be recommended.**

**I recognize that, there may be redness, irritation, hyperpigmentation and/or hypopigmentation that may develop after the peel. It may persist for weeks or months and will improve as directions to home care are followed.**

**I understand that, once the desired results are achieved, maintenance peels are necessary to sustain the results, and it is essential to follow up on all post-care instructions. The frequency and depth depends on the individual’s own genetics, age and lifestyle.**

**These services are cosmetic in nature, and are nonrefundable. I understand that payment at time of service is my sole responsibility.**

**No guarantee can be made that the skin will physically flake or peel. Initial here: \_\_\_\_\_\_\_**

Patient Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date:**­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Orlando Plastic Surgery Institute**

DERMAPEN INFORMED CONSENT

1. I have requested a Dermapen Treatment to attempt to improve my facial expression lines and/or skin surface with the Dermapen Treatment.

The practice of medicine is not an exact science and no guarantees can be or have been made concerning expected results. I understand that several appointments may be necessary to complete this treatment.

1. These services are cosmetic in nature, and are non- refundable. I understand that payment is my sole responsibility.
2. Once the desired results are achieved, I understand maintenance may be necessary to sustain results. The frequency depends on the individual’s own genetics, age, and lifestyle.
3. **Arbitration Agreement** – Patient consents that any controversy between Orlando Plastic Surgery Institute and the patient shall be settled by arbitration in accordance with the then-current commercial arbitration rules of the American Arbitration Association, and judgment on the award rendered by the arbitrator(s) may be rendered by any court having jurisdiction thereof. Orlando Plastic Surgery Institute and patient shall share the costs of the arbitrator equally but shall each bear their own costs and legal fees associated with the arbitration. The location of the arbitration shall be in Orlando, Florida.

**RISKS AND SIDE EFFECTS:**

Side effects and complications are usually minimal. I understand that I may experience erythema, bleeding, scarring, infection, dryness, and/or discomfort. I have been advised of the risks involved in such treatment, the expected benefits of such treatment, and alternative treatments, including no treatment at all.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and that I have had sufficient opportunity for discussion and to ask questions. I consent to this procedure today and for all subsequent treatments.

Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Orlando Plastic Surgery Institute**

INFORMED KENALOG INJECTION CONSENT

Intralesional and subcutaneous steroid injections are often performed to decrease pain, swelling and inflammation. This procedure consists of a steroid suspension injected into the skin in a sterile fashion.

I understand there is a possibility of side effects such as atrophy (temporary or permanent depression of the skin), permanent scarring, temporary redness and bruising, hyperpigmentation, pain and hypersensitivity. I also understand that multiple injections may be required before my condition improves and that my condition may not improve even after recurrent treatment.

I have read the above and understand it. I have been given the opportunity to ask questions and they have been answered to my satisfaction. I accept the risks and complications of this procedure as stated above and consent to the terms of this agreement.

**Arbitration** **Agreement**: Patient consents that any controversy between Orlando Plastic Surgery Institute and the patient shall be settled by arbitration in accordance with the then-current commercial arbitration rules of the American Arbitration Association, and judgment on the award rendered by the arbitrator(s) may be rendered by any court having jurisdiction thereof. Orlando Plastic Surgery Institute and patient shall share the costs of the arbitrator equally but shall each bear their own costs and legal fees associated with the arbitration. The location of the arbitration shall be in Orlando, Florida.

Patient’s Signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Orlando Plastic Surgery Institute**

INFORMED CONSENT FOR LATISSE™ TREATMENT

(Treatment for hypotrichosis)

**WHAT ARE THE INDICATIONS FOR LATISSE™ TREATMENT?**

Latisse™ is the brand name for bimatoprost, a sister medication already FDA approved for the treatment of glaucoma known as Lumigan®. LatisseTM is FDA approved for the treatment of hypotrichosis of the eyelashes by making them grow longer, thicker and darker. Hypotrichosis is a medical term for short or missing lashes. It is frequently seen in men and women as they approach middle age. Latisse™ is believed to affect the growth (anagen) phase of the eyelash hair cycle by increasing the length of the growth phase and increasing the number of hairs along the eyelid margin. The onset of action is gradual with most users seeing a significant improvement in the length and number of lashes by 2 months. If Latisse™ is discontinued the eyelashes and eyelids will return to their previous appearance over several weeks to months.

**Alternatives:** There are no FDA approved alternatives. You may decide that you do not want to use Latisse**™** now and are willing to live with short or missing eyelashes.

**WHAT ARE THE RISKS and POSSIBLE SIDE EFFECTS OF USING LATISSE™?**

1. The following side effects are the most frequently reported, but occur in less than 4% of users (i.e. 4 out of 100 users):
	1. Eye irritation and itching
	2. Conjunctival hyperemia or red eye (redness of the white, moist covering of the eyeball)
	3. Dry eye symptoms
	4. Eyelid redness
2. Although rare, Latisse™ has the potential to permanently increase the brown pigmentation of the iris (colored part of the eyeball, inside the eye).
3. Latisse™ may cause hyperpigmentation or darkening of the eyelid skin which may or may not be reversible upon discontinuation of the treatment.
4. Latisse™ may lower intraocular pressure (IOP) or pressure inside the eye; however, the magnitude of this reduction is usually not a cause for concern.
	1. If you have a history of abnormal eye pressures or glaucoma you should only use Latisse™ under the close supervision of your ophthalmologist.
	2. Inform anyone conducting an eye pressure examination that you are using Latisse™.
5. You should inform your ophthalmologist that you are using Latisse™ if eye surgery is planned.
6. Do not use Latisse™ if you are allergic or hypersensitive to bimatoprost (LumiganR) or any other ingredient in this product.
7. Latisse™ is intended for use on the skin at the base of the eyelashes of the UPPER eyelids only.
8. DO NOT APPLY to the lower eyelids as this will increase the chance of side effects such as hyperpigmentation or darkening of the eyelid skin.
9. You should discontinue use of Latisse™ and call your physician immediately if you develop an eye infection, sudden decrease in vision, suffer eye trauma, or develop eye or eyelid reactions.

**WHAT ARE THE CONTRAINDICATIONS OF USING LATISSE™?**

You should NOT use Latisse™ if: you are allergic or hypersensitive to bimatoprost (LumiganR)or any other ingredient in this product; are about to undergo cataract or other eye procedures, have an eye infection, or are being treated for glaucoma with eye drops, unless cleared by your treating ophthalmologist.

**PATIENT’S ACCEPTANCE OF RISKS**

I have read the above information and have discussed it with my physician. I understand that it is impossible for the physician to inform me of every possible complication that may occur. My physician has told me that results cannot be guaranteed. By signing below, I agree that my physician has answered all of my questions and I give informed consent to proceed with Latisse™ treatment.

Patient Signature Date

Witness

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**Orlando Plastic Surgery Institute**

INFORMED CONSENT/MODEL CONSENT

To the patient: You have the right to be informed about your skin condition and the treatment so that you may make an informed decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare, or alarm you, it is simply an effort to better inform you so that you may give or withhold your consent for the treatment.

1. I understand that the treatment I am about to undergo is for training purposes only. **Initial if true:** \_\_\_\_\_\_\_\_
2. I understand that my decision to partake in this training is purely elective and that Orlando Plastic Surgery Institute, Dr. Anup Patel or staff has explained to me the nature and purpose of the course of treatment, administration and possible alternate methods of treatment, the expected benefits and complications, attendant discomforts and risk involved. I have been given the opportunity to ask questions and all of my questions have been fully and satisfactorily answered. I freely assume any known and unknown risks associated with this procedure. In the event that any unforeseen reaction should arise from this procedure, I will notify Orlando Plastic Surgery Institute immediately.

 **Initial:** \_\_\_\_\_\_\_\_

1. I understand that additional treatment may be required following this training exercise. I understand that payment for any additional treatment will be my responsibility.

**Initial:** \_\_\_\_\_\_\_\_

1. **Complimentary touch-ups are NOT included in this training exercise.** Any additional treatment that may be required following today’s training exercise will be my financial responsibility at Orlando Plastic Surgery Institute’s normal pricing structure (below).

|  |  |
| --- | --- |
| Botox: $600 for full facial treatment | Restylane-L: $900 (1mL) |
| Juvederm Ultra XC: $900 (1mL) | Perlane-L: $900 (1mL) |
| Juvederm Ultra Plus: $900 (1mL) | Belotero: $575 |
| Juvederm Vollure: $1000 (1mL) | Radiesse: $500 (.8cc), $900 (1.5cc) |

 **Initial:** \_\_\_\_\_\_\_\_

1. I agree to adhere to all safety precautions and regulations during the treatment. I am aware and will follow post procedure instructions such as; staying in an upright position for 4 hours following the treatment and abstaining from alcohol and strenuous exercise for the next 6 hours. **Initial:** \_\_\_\_\_\_\_\_
2. **PAYMENT**: This procedure is cosmetic in nature and non refundable; I understand that payment will be my responsibility.**Initial:** \_\_\_\_\_\_\_\_
3. **Arbitration** **Agreement** – Patient consents that any controversy between Orlando Plastic Surgery Institute and the patient shall be settled by arbitration in accordance with the then-current commercial arbitration rules of the American Arbitration Association, and judgment on the award rendered by the arbitrator(s) may be rendered by any court having jurisdiction thereof. Orlando Plastic Surgery Institute and patient shall share the costs of the arbitrator equally but shall each bear their own costs and legal fees associated with the arbitration. The location of the arbitration shall be in Orlando, Florida. **Initial:** \_\_\_\_\_\_\_\_

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion and to ask questions.

Patient’s Signature: Date:

Clinician Signature: Date:

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**Orlando Plastic Surgery Institute**

INFORMED KYBELLA™ (DEOXYCHOLIC ACID) INJECTION CONSENT

To the patient: You have the right to be informed about your skin condition and the treatment so that you may make an informed decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare, or alarm you, it is simply an effort to better inform you so that you may give or withhold your consent for the treatment.

1. I hereby consent to Orlando Plastic Surgery Institute, Dr. Anup Patel and members of the staff to administer multiple injections of Kybella™ (deoxycholic acid) and related services to me in the judgment of Dr. Anup Patel and members of his staff. Kybella™ is indicated for improvement in the appearance of moderate to severe convexity or fullness associated with submental fat in adults (“double chin”). I understand that in rendering treatment to me, Orlando Plastic Surgery Institute clinical providers will exercise their best skills and judgment as a medical professional but do not warrant and guarantee with respect to the results of this procedure.

 **Initial:** \_\_\_\_\_\_\_\_

1. I understand there are potential risks and complications regarding Kybella™ injections. These include but are not limited to pain, bruising, redness, poor result, discoloration, nodules, bleeding, numbness, persistent swelling, asymmetry, nerve injury, allergic reaction, itching, skin tightness, site warmth, headache, nausea, difficulty swallowing, hypertension, dizziness, lymphadenopathy and infection. In the event that any unforeseen reaction should arise from this procedure, I will notify Orlando Plastic Surgery Institute immediately.

 **Initial:** \_\_\_\_\_\_\_\_

1. I understand that I may require multiple treatment sessions (sometimes up to 6 or more treatment sessions may be needed) in order to obtain the best possible results.

 **Initial:** \_\_\_\_\_\_\_\_

1. No guarantee has been given to me regarding the outcome of this procedure(s).

 **Initial:** \_\_\_\_\_\_\_\_

1. The above points, among others, have been specifically made clear. I understand that this procedure is purely elective and Orlando Plastic Surgery Institute, Dr. Anup Patel, or staff has explained to me the nature and purpose of the course of treatment, administration and possible alternate methods of treatment, the expected benefits and complications, attendant discomforts and risk involved. I have been given the opportunity to ask questions and all of my questions have been fully and satisfactorily answered. I freely assume any known and unknown risks associated with this procedure.

 **Initial:** \_\_\_\_\_\_\_\_

1. I agree to adhere to all safety precautions and regulations during the treatment. I am aware and will follow post procedure instructions such as; abstaining from alcohol and strenuous exercise for the next 24 hours.

 **Initial:** \_\_\_\_\_\_\_\_

1. **PAYMENT**: This procedure is cosmetic in nature and non-refundable. I understand that payment will be my responsibility and is due at the time of treatment. If an enhancement or touch up of the treated area is necessary, which is typically performed 4-8 weeks after the prior treatment, there will be an additional charge for this treatment.

 **Initial:** \_\_\_\_\_\_\_\_

1. **Arbitration** **Agreement** – Patient consents that any controversy between Orlando Plastic Surgery Institute and the patient shall be settled by arbitration in accordance with the then-current commercial arbitration rules of the American Arbitration Association, and judgment on the award rendered by the arbitrator(s) may be rendered by any court having jurisdiction thereof. Orlando Plastic Surgery Institute and patient shall share the costs of the arbitrator equally but shall each bear their own costs and legal fees associated with the arbitration. The location of the arbitration shall be in Orlando, Florida.

 **Initial:** \_\_\_\_\_\_\_\_

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion and to ask questions.

**Patient’s Signature:**  **Date**: