TriHealth
Cosmetic Surgery &
Rejuvenation Center

Patient Name _____ Date of Birth _____ Sex ☐M ☐F

Address _____

City/ST/Zip _____

Primary Phone _____ Secondary Phone _____

Procedure Payment Policy

At our facility, we perform elective procedures that are not covered by insurance or healthcare reimbursement programs. So please be aware that, under no circumstances, does this office file insurance claims for elective cosmetic procedures. You, the patient, will be financially responsible, in accordance with this Procedure Payment Policy, for any elective cosmetic procedures performed at TriHealth Cosmetic Surgery and Rejuvenation Center.:

- **Consultation Fee:** The consultation fee with our Cosmetic Center Physician is $100. All patients are obligated to pay this fee prior to their appointment. During that first visit, you and the provider will discuss your medical history, explore options, establish expectations and develop a treatment plan. The $100 consultation will be applied to any procedure or surgery that is performed within three (3) months of the payment. In the event that multiple surgeries are performed during the three-month period, the consultation fee will only be deducted one time. The consultation fee will be applied to Botox® or other injectables only if you have your treatment injection the day of the consultation.
- **Cost Estimate:** You will be given a cost-estimate for the anticipated procedures on the day of your initial consult. To schedule a procedure and to secure your desired date, we must obtain a deposit, which is determined based on the cost of the cosmetic procedure.
- **Pre-Payment for Procedure/Surgery:** The remaining balance of the fees will be due two weeks prior to the scheduled procedure/surgery. Because these times are reserved specifically for you, if you need to cancel the procedure/surgery less than two weeks prior, 50% of the total cost is forfeited. If the procedure/surgery is cancelled within less than 72 hours, then the total cost is completely forfeited. However, in the event surgery is postponed by our office due to patient medical condition, inclement weather or unforeseen circumstances, every effort will be made to reschedule and accommodate you, or a full refund will be issued. A full refund will also be offered if the physician deems that the remaining treatments in a package are not advisable or required for the finished result.

I have read and understand this Procedure Payment Policy of TriHealth Cosmetic Surgery and Rejuvenation Center and agree to comply with its terms.

_____ _____

Patient's Signature (Parent if patient is minor) Date

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Patient Name _____ Date of Birth _____ Sex ☐M ☐F

Address _____

City/ST/Zip _____

Primary Phone _____ Secondary Phone _____

E-mail _____

General Consent

Consent to Treat I consent to examination, diagnosis, and general medical care and treatment (including but not limited to physical examinations; administration of medications and vaccinations, including numbing agents and nitrous gases; recordings and/or photographs for diagnosis, treatment and/or educational purposes; taking of x-rays, blood draws, diagnostic tests, laboratory tests and other minor procedures) to be performed by employees, including but not limited to physicians, nurses, and assistants of TriHealth, Inc. and its subsidiaries (hereinafter "TriHealth").

I understand that Ohio law gives me the right to have an HIV test performed on me anonymously (my identity will be unknown) but that Ohio law does not require health care facilities to make anonymous HIV testing available. TriHealth does not provide anonymous HIV testing. By signing below, I acknowledge and agree that I am waiving my right to an anonymous test and that any HIV test ordered on me within TriHealth will be performed on a non-anonymous basis. In other words, my identity and test results will be maintained in my confidential TriHealth medical record and may be known to the healthcare providers who are treating me.

I understand that my protected health information will be used by TriHealth, as necessary, for my treatment, to obtain payment for this treatment, and for the health care operations of TriHealth. I also understand that my protected health information will be disclosed to other TriHealth affiliates if needed for the purpose of furthering my treatment, to obtain payment for treatment and for health care operations of TriHealth.

I understand that TriHealth will warn the appropriate authorities and/or other individuals if my TriHealth care giver determines that I am a harm to myself or to others.

I understand that if at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not limited to communications regarding appointment reminders, billings and payment for items and services, unless I notify TriHealth in writing. Such calls and text messages may be delivered via artificial or pre-recorded messages, automatic telephone dialing devices or other computer assisted technology, e-mail text messages, or by any other form of electronic communication from TriHealth, its affiliates, contractors, providers, or agents including collection agencies.

X _____ _____

Patient Signature Date/Time

More on reverse ▶

Payment TriHealth will not bill any insurance company (including Medicare, Medicaid or commercial insurance) for any services provided in TriHealth Cosmetic Surgery and Rejuvenation Center. You acknowledge that you are responsible for payment and have read and agreed to our Procedure Payment Policy.

X _____ _____

Patient Signature Date/Time

Acknowledgment of Receipt of Notice of Privacy Practices

HIPAA requires that TriHealth give you a Notice of Privacy Practices that describes how TriHealth will use and disclose your protected health information and explains your HIPAA Privacy Rights.

I have received a copy of the Notice of Privacy Practices.

X _____ _____

Patient Signature Date/Time

Staff: If the patient did not sign the Acknowledgment of Receipt of the Notice above, you must document below your efforts to obtain the patient's acknowledgment and the reason why it was not obtained and scan the consent into the patient's electronic chart.

The staff member attempted to give the Notice to the patient but the patient did not sign the acknowledgment above because (complete below):

☐ Patient refused to sign

☐ Other reason (Staff: insert reason): _____

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Patient Name _____ Date of Birth _____ Sex ☐M ☐F

Address _____

City/ST/Zip _____

Primary Phone _____ Secondary Phone _____

Condition _____ Treatment Location _____

Practitioner _____

Informed Consent To Perform Laser Treatment/Therapy

I acknowledge that my practitioner (listed above) and I have talked about my condition as described above. My practitioner explained the purpose, anticipated benefits, material risks, discomforts, alternatives (including risks/benefits), likelihood of achieving my goals by receiving laser treatment/therapy, and the potential problems that might occur during recovery. I consent to allow the treatment to be performed at the above location.

I understand the purpose and anticipated benefit of this treatment is treatment/improved appearance of darkened areas on the skin (sun spots, age spots and other skin discolorations), vascular lesions (red spots, leg veins, small spider veins, but not varicose veins), wrinkles, furrows, fine lines, textural irregularities, skin resurfacing, and reducing or eliminating hair.

I understand my practitioner cannot tell me every possible risk, but we did talk about and I understand the more common risks, including but not limited to: a pinprick sensation or flash of heat, redness/swelling for 2-24 hours or longer (cooling the area using ice can decrease symptoms), temporary redness and mild sunburn-like symptoms, crusting, irritation, itching, burning, scabbing, bronzing, broken capillaries and pain. Skin coloration changes including hyperpigmentation (darkening) and hypopigmentation (lightening) may occur and last 6 months or even become permanent. Freckles in the area may permanently or temporarily disappear. There is a possibility of not achieving the desired result. Serious complications are rare, but possible, such as blood clots, skin loss, hematomas (blood collections under the skin), or allergic reactions to medications or materials used during the procedure. An occlusive ointment may be used to cover the treated skin and to keep it moist to prevent it from drying out or crusting. Sun and tanning bed exposure should be avoided. Sunblock of at least SPF 30 should be used after treatment. Failure to adhere to post procedure instructions may increase the risk of complications. Some partial or full hair removal could occur as part of the procedure.

The possible alternatives to this procedure include, but are not limited to: topical medications, other dermatological procedures, and other medical dermatology treatment typical for my condition, or no treatment at all. My doctor and I discussed the risks and benefits of these alternatives.

I understand that no guarantee has been made to me of the results of this treatment. I may require additional treatment. My condition may not improve, or may even become worse as a result of this procedure. We discussed the likelihood of achieving my goals with the above treatment.

I consent to the taking of photographs to document clinical outcomes at my practitioner's discretion. I understand that these photographs will become a part of my medical record.

I have read this form or had it read to me, fully understand the risks, benefits and alternatives, and had all of my questions answered to my satisfaction.

X _____ AM/PM

Patient/Legal Representative Signature (if applicable) | Relationship of Legal Representative | Date/Time

X _____ AM/PM

Witness Signature | Witness Name | Date/Time

I have explained to the patient: the purpose of the above care and any reasonable alternatives, the anticipated benefits, the material risks, the likelihood of the patient achieving his/her goals, the potential problems that might occur during recovery, and the reasonably likely result of not receiving the care.

X _____ AM/PM

Physician/Practitioner Signature | Date/Time

TriHealth
Cosmetic Surgery &
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Patient Name _____ Date of Birth _____ Sex ☐M ☐F

Address _____

City/ST/Zip _____

Primary Phone _____ Secondary Phone _____

Areas to be injected _____

Practitioner _____

Informed Consent for Cosmetic Filler Injections

I acknowledge that my practitioner (listed above) has talked with me about the options for cosmetic filler injections. I consent to allow my practitioner to inject in the area(s) listed above. My practitioner explained the purpose, anticipated benefits, material risks, discomforts, alternatives (including risks/benefits), likelihood of achieving my goals by receiving the treatment, and the potential problems that might occur during recovery. I consent to allow the treatment.

I understand the purpose and anticipated benefit of this treatment is cosmetic in nature, and intended to temporarily eliminate or reduce the appearance of fine lines and wrinkles in the area of the injection and/or to temporarily enhance the appearance/fullness of lips. Because the treatment is cosmetic, I know insurance will not cover it, and I am responsible for payment.

I understand my practitioner cannot tell me every possible risk and benefit, but we did talk about and I understand some of the more common risks, including but not limited to: infection, bleeding, allergic reaction, bruising, swelling, itching, redness, pain, unsatisfactory cosmetic appearance, the formation of nodules or bumps in the area of the injection, localized superficial necrosis (tissue death), possible blindness, stroke, scarring, and the need for possible/additional touch-up procedures. The practice of medicine and surgery is not an exact science and I know that the nature of the results and risks are not completely predictable.

The alternatives to this treatment include receiving no treatment, other types of injections, laser treatments and more permanent procedures, such as plastic surgery. My practitioner and I talked about these alternatives, including the risks and benefits.

I understand that no guarantee has been made regarding the results of this treatment, and I also understand it may not be possible to achieve optimal results with a single injection. I may require additional injections.

I attest to all of the following: I do not have a history of severe allergies; I do not have a history of allergies to material found in gram positive bacterial proteins; I am not pregnant or breast feeding; I am not on any immunosuppressive medication.

I consent to the taking of photographs to document clinical outcomes at my practitioner's discretion. I understand that these photographs will become a part of my medical record.

I have read this form or had it read to me, fully understand the risks, benefits and alternatives, and had all of my questions answered to my satisfaction.

X _____ AM/PM
Patient/Legal Representative Signature (if applicable) Relationship of Legal Representative Date/Time

X _____ AM/PM
Witness Signature Witness Name Date/Time

I have explained to the patient: the purpose of the above care and any reasonable alternatives, the anticipated benefits, the material risks, the likelihood of the patient achieving his/her goals, the potential problems that might occur during recovery, and the reasonably likely result of not receiving the care.

X _____ AM/PM
Physician/Practitioner Signature Date/Time

TRM (1/2018)

TriHealth
Cosmetic Surgery &
Rejuvenation Center

Patient Name _____

Address _____

Primary Phone _____ Secondary Phone _____

Last 4 digits of SSN_____ Maiden Name _____

Date of procedure _____ Physician _____

Authorization for Disclosure of Protected Health Information for Educational or Marketing Purposes

Authorization: I authorize TriHealth to disclose recorded video(s) or image(s) before and/or after a medical appointment, surgery or medical procedure performed at a TriHealth facility on the date above by the practitioner above ("Physician") to use for the purposes described below.

Further, I authorize the release of any information contained in the recording concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism and/or Acquired Immune Deficiency Syndrome (AIDS) and/or testing for antibodies to the AIDS virus (HIV) and/or psychiatric/psychological conditions and/or psychiatric/mental health treatment, if any.

Purpose for the Use or Disclosure: The purpose for the use or disclosure is to permit the Physician to use any recorded video(s) or image(s) of me, before and/or after a medical appointment, surgery or other medical procedure performed at a TriHealth facility for any educational or marketing purposes, whether inside or outside of TriHealth, including, but not limited to, national conferences, marketing materials, publications, and/or scholarly journals and submissions. I understand that the use or disclosure to Physician is limited to videos, photographs, or other visual media which shall not include my name but may include other identifying information, such as the type of surgery or other medical procedure, or tattoos or other unique characteristics that may identify me.

Oral Communications: I understand that this Authorization allows the TriHealth (and its employees) to discuss my protected health information described herein with the recipient of the information.

Your Refusal to Sign this Authorization: The Health Care Provider may not condition treatment on whether or not you sign this Authorization. If you refuse to sign this Authorization the Health Care Provider will not withhold treatment from you and will not release the information to the person specified above.

Re-disclosure: I understand that the information used and/or disclosed pursuant to this Authorization may be re- disclosed by the recipient of the information and may no longer be protected by Federal law. However, if the information disclosed pursuant to this Authorization includes alcohol or drug treatment records, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit such person(s) from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the patient to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. If the information disclosed pursuant to this Authorization includes the identity of an individual on whom an HIV test is performed, HIV test results or AIDS- related treatment

More on reverse ▶

information, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from confidential records protected from disclosure by Ohio law. Ohio law prohibits such person(s) from making any further disclosure of this information without the specific, written, and informed release of the patient to whom it pertains, or as otherwise permitted by Ohio law. A general authorization for the release of medical or other information is not sufficient for the purpose of the release of HIV test results or diagnoses.

Revocation: I understand that I may revoke this Authorization at any time by notifying the Health Care Provider in writing by sending a letter to the attention of the Manager of the Medical Records Department at the Health Care Provider's mailing address. I understand that if I revoke this Authorization, it will not affect any actions that the Health Care Provider took before it received my revocation letter.

Expiration: This Authorization will expire upon Physician's receipt of the video(s) or image(s) recorded before and/or after a medical appointment, surgery or medical procedure performed at TriHealth.

X _____ _____

Signature of Patient or Patient's Representative Date

_____

Printed Name of Patient's Representative (if applicable)

Relationship to patient: ☐ Legal Guardian* ☐ Other: _____

*Legal documentation of representative's authority must accompany this authorization.