HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information is information or mental health or condition and related health care services."

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you or your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Patient Name: ____ Date: _________________

Patient Signature:____

GENERAL SURGICAL CONSENT

MEDICATIONS DISCLOSURE

I have disclosed all the medications, supplements and herbal remedies I take on a regular or incidental basis to my surgeon. I fully understand that my surgery may have to be rescheduled or postponed if I have not complied with the medication instructions/restrictions provided by my surgeon. I also understand that it is my responsibility to obtain clearance from the prescribing physician before I stop taking any of my regularly prescribed medications. Please notify our office immediately if you do not receive clearance to stop taking your prescribed medications. Your safety in surgery requires that you disclose all medications, vitamins, and supplements that you regularly take. In the days prior to surgery, you may be required to stop taking certain medications, vitamins, and supplements, both those you regularly take, and those that may be taken incidentally for pain or other symptoms. Please notify our office of all medications you take during the 14 days prior to surgery. This is for your safety. Aspirin, aspirin-containing medications, and anti-inflammatory agents must not be taken in the two weeks prior to your scheduled surgery date. Always read the active ingredients on any over-the-counter or prescription medications. Anti-inflammatory medications fall under a separate category that must also be discontinued two weeks prior to your scheduled surgery date.

GENERAL SURGICAL RISKS

About Risks

We want you to fully understand the risks involved in surgery so that you can make an informed decision. Although complications are infrequent, all surgeries have some degree of risk. All of us at Cosmetic Surgery Affiliates Jacksonville will use our expertise and knowledge to avoid complications so far as we are able. If a complication does occur, we will use those same skills to solve the problem quickly. The importance of having a specialized and qualified medical team and the use of a state-of-the art facility cannot be overestimated. In general, the least serious problems occur more often, and the more serious problems occur very rarely. If a complication does arise, you, the physician, and the nursing staff will need to cooperate in order to resolve the problem. Most complications involve an extension of the recovery period rather than any permanent effect on your result. This may involve an unplanned admission to a hospital or an overnight stay within our facility and an evaluation in the morning.

Normal Symptoms

Swelling and bruising: Moderate swelling and bruising are normal after any surgery. Severe swelling and bruising may indicate bleeding or possible infection.

Discomfort and Pain

Mild to moderate discomfort is normal after any surgery. If the pain becomes severe and is not relieved by pain medication, please call us at (904)-648-6440.

Incision line crusting

Daily soap and water washes will ensure cleanliness. We usually treat this with antibiotic ointment.

Numbness

Small sensory nerves to the skin surface are occasionally cut when the incision is made or interrupted by undermining of the skin during surgery. The sensation in those areas gradually returns, usually within three to six months as the nerve endings heal.

Itching

Itching and occasional small shooting electrical sensations within the skin frequently occur as the nerve endings heal. Ice and skin moisturizers are frequently helpful. These symptoms are common during the recovery period.

Redness of scars

All new scars are red, dark pink, or purple. Scars on the face usually fade within three to six months. Scars on the breasts or body may take a year longer to fade completely.

Common Risks

Hematoma: Small collections of blood under the skin are usually allowed to absorb spontaneously. Larger hematomas may require aspiration, drainage, or even surgical removal to achieve the best result. Inflammation and infection: A superficial infection may require antibiotic ointment. Deeper infections are treated with antibiotics. Development of an abscess usually requires drainage. Thick, wide, or depressed scars: Abnormal scars may occur even though we have used the most modern cosmetic surgery techniques. Injection of steroids into the scars, placement of silicone sheeting onto the scars, or further surgery to correct the scars is occasionally necessary. Some areas on the body scar more than others and some people scar more than others do. Your own history of scarring should give you some indication of what you can expect. Wound separation or delayed healing: Any incision during the healing phase may separate or heal slowly for several reasons. These include inflammation, infection, wound tension, decreased circulation, smoking, or excess external pressure. If delayed healing occurs, the outcome is usually not significantly affected, but secondary revision of the scar may be indicated. Sensitivity or allergy to dressings/tape: Occasionally, allergic or sensitivity reactions may occur from soaps, ointments, tape, or sutures used during or after surgery. Such problems are unusual and are usually mild and easily treated. In extremely rare circumstances, allergic reactions can be severe and require aggressive treatment or even hospitalization. Injury to deeper structures: Blood vessels, nerves, and muscles may be injured during surgery. This incidence of such injuries is rare.

More Rare

If they are severe, any of the problems mentioned under Common Risks may significantly delay healing or necessitate further surgical procedures. Lidocaine toxicity pertaining to lipoplasty: There is the possibility that large volumes of fluid containing diluted local anesthetic drugs and epinephrine that is injected into fatty deposits during surgery may contribute to fluid overload or systemic reaction to these medications. Additional treatment, including hospitalization, may be necessary.

Complications

Medical complications such as pulmonary embolism, severe allergic reactions to medications, cardiac arrhythmias, heart attack, and hyperthermia are rare but serious and life threatening. Having a dedicated and sub-specialized medical team reduces these risks as much as possible. Failure to disclose all pertinent medical data before surgery may cause serious problems for you and for the medical team during surgery.

Unsatisfactory Result and Need for Revision Surgery

All cosmetic surgery treatments and operations are performed to improve a condition, a problem, or appearance. While the procedures are performed with a very high probability of success, disappointments occur, and results are not always acceptable to patients or the surgeon. Secondary procedures or treatments may be indicated. Rarely, problems may occur that are permanent. POOR RESULTS: Asymmetry, unhappiness with the result, poor healing, etc. may occur. Minimal differences are usually acceptable. Larger differences frequently require revision surgery. This may result in additional changes. Please see our revision policy for details.

Other Risks

We have outlined the common and not so common risks of surgery in general. We have discussed every possible problem that may occur, and you cannot assume that a problem will not occur simply because it is not discussed here.

I acknowledge that the risks and complications of the surgery I am to undergo have been explained and discussed with me in detail by Dr. Nuveen and by the nursing staff. I have been given the opportunity to ask questions and any concerns I had about my surgery have been explained to me.

Smoking Risks

We strive to offer the finest surgery available and most predictable outcomes for our patients. Smoking significantly increases the risks associated with poor outcomes in all types of surgery. As a result, we request that all patients who smoke quit for at least two weeks prior to surgery and remain smoke free for at least two weeks after surgery. This minimizes the risks of poor wound healing, increased scarring, and need for further surgery. A history of smoking is always a cause for caution when choosing an elective surgery and those risks cannot be eliminated, only reduced by this protocol.

This above statement has been read, completely understood and your questions have been answered regarding the well-known risks of smoking and poor outcomes for surgery of any kind. Your signature below acknowledges this discussion, our recommendations and your understanding of those increased risks of a poor outcome.

CONSENT FOR SURGERY

I desire the physicians at CSA, and such assistants, as may be assigned, to perform the elective procedure(s). I recognize that during the operation and medical treatment or anesthesia, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the physicians and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted shall include all conditions that require treatment and are not known to my physician at the time the procedure is begun. I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involve risk and the possibility of complications, injury, and sometimes death. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained. I consent to the photographing or televising of the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures. For purposes of advancing medical education, I consent to the admittance of observers to the operating room. I consent to the disposal of any tissue, medical devices or body parts which may be removed. I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical-device registration, if applicable. The above information has been explained to me in a way I understand and as completely as possible, to my satisfaction. I understand that there are options available to the proposed treatment including the option to do nothing. I accept the well-known, common, and uncommon risks of this procedure and I consent to the performance of the described procedure.

FOLLOW-UP INSTRUCTIONS

For the first 24 hours following surgery, a responsible adult over the age of 18 must drive you and stay with you because you have been sedated. If you stay overnight in our facility, you will need an adult caregiver to stay with you or a caregiver from our staff can be provided for an additional fee. If you have excessive bleeding or pain, call the office at (904) 648-6400 during the day. Your physician's cell phone number is provided in your follow up directions to take with you. If you have any questions about these matters, please ask one of our nursing staff. You will be provided with printed follow-up instructions on the day of your surgery that will be reviewed with you and your caregiver prior to your procedure. Please retain these instructions for reference.

Ice Packs

Cold or ice packs help to reduce swelling, bruising, and pain. Use frozen peas in the package or place ice cubes into a sealable plastic bag, unless specifically instructed not to by your surgeon. This should help, not hurt. If the ice feels too uncomfortable, don't use it as often. Leave it in place no longer than 20 minutes on and 20 minutes off per area. Rotate ice placement for 24 hours. Under no circumstances should heat be applied.

Diet

If you have any post-operative nausea, carbonated sodas and dry crackers may settle the stomach. If nausea is severe, use medication provided or prescribed. If you feel normal, start with liquids and bland foods. If those are well tolerated, progress to a regular diet.

Alcohol

Alcohol dilates the blood vessels and could increase post-operative bleeding. Please do not drink until you have stopped taking the prescription pain pills, as the combination of pain pills and alcohol can be dangerous.

Driving

Do not drive while taking prescription pain pills. Please be advised that all medications may impair judgment and the ability to drive or operate heavy machinery.

Post-Operative Appointments

It is very important that you comply with the recommended follow-up we establish after surgery - 24 hours, one week, one month, three months, and six months, or as needed to address any questions or concerns. This can be achieved through in-office appointments, by emailing photos to your nurse, or a combination of both.

I have received, read and understand the importance of following & adhering to the follow-up instructions listed.

CONSENT FOR IV SEDATION

You have chosen IV sedation/general anesthesia for your surgery, a common procedure that is considered quite safe. Nevertheless, any anesthesia carries some risk and the common ones known for intravenous sedation are noted below for your review before you consent to its use:

- Discomfort, swelling, or bruising at the site where the drugs are placed into a vein.
- Vein irritation, called phlebitis, where the needle is placed into a vein. Sometimes this may progress to a level of discomfort where arm or hand motion may be restricted, or further medication or care may be required.
- Nausea and vomiting, although not common, are unfortunate side effects of intravenous anesthesia. Bed rest, and sometimes medications, may be required for relief.
- Intravenous sedation is a serious medical procedure and whether given in a hospital or office, carries with it the risk of brain damage, stroke, heart attack, or death.

Your Obligations:

Because the anesthetic medication (including oral premedication/sedation) causes prolonged drowsiness, you must be accompanied by a responsible adult to drive you to and from surgery and stay with you for several hours until you are recovered sufficiently to care for yourself. Sometimes the effects of the drugs do not wear off for 24 hours. During recovery time (normally 24 hours), you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents. You must have a completely empty stomach. It is vital that you have nothing to eat or drink for eight hours prior to your anesthetic. TO DO OTHERWISE MAY BE LIFE THREATENING. Note: If directed by your doctor, sips of water may be used to take regular medications or prescriptions given to you by this office.

I have read & understand the information listed on the Consent for IV Sedation and realize that intravenous sedation/general anesthesia carries with it certain serious risks. I request that intravenous sedation be used for my surgery. All my questions regarding this consent have been answered fully and to my satisfaction. I fully understand the

risks involved. I do not request hospitalization for my anesthetic. I certify that I speak, read and write the English language or have a translator present.

REVISION POLICY

There is extreme variation in the healing process among all patients. Due to the uncertain nature of healing, a patient may elect to have additional surgery performed to modify results of their original surgery for better results and increased patient satisfaction. As in all surgery, both the physician and patient must mutually agree that a revision procedure could further improve the initial results and at the benefit of such a revision would outweigh the risks.

- There will be a minimum charge of $1,500 for the use of the facility, staffing, supplies, anesthesia, and materials to perform revision surgery within the first year following your primary procedure.
- There will be a minimum charge of $2,500 for any revision performed after the first year following a primary procedure.
- Additional fees may be appropriate and will be individually determined in consultation.

At no time will this agreement constitute and admission of guilt or responsibility.

No surgical procedure will be scheduled without receiving our predetermined fee.

This policy has been presented prior to surgery in order to more fully inform patients and limit uncertainty of possible charges in the future. We feel this is an extremely generous offering and consider it part and proof of our efforts to provide patients with the highest level of satisfaction.

Examples include but are not limited to:

- Undesirable scarring
- Breast asymmetry
- Areolar shape
- Capsular contraction
- Dog ear formation
- Irregularity after liposuction
- Modification of the shape or position of the belly button
- Nasal irregularities
- Airway compromise

Patient Name: ______________________________________ Date: _________________

Patient Signature:____

CONSENT FOR ANESTHESIA SERVICES

I, ______________________________________, acknowledge that my doctor has explained to me that I will have an operation, diagnostic or treatment procedure. My doctor has explained the risks of the procedure, advised me of alternative treatments and told me about the expected outcome and what could happen if my condition remains untreated. I also understand that anesthesia services are needed so that my doctor can perform the operation or procedure.

It has been explained to me that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my procedure or treatment. **Although rare, unexpected severe complications with anesthesia can occur and include the remote possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death.** I understand that these risks apply to all forms of anesthesia and that additional or specific risks have been identified below as they may apply to a specific type of anesthesia. I understand that the type(s) of anesthesia service checked below will be used for my procedure and that the anesthetic technique to be used in determined by many factors including my physical condition, the type of procedure my doctor is to do, his or her preference, as well as my own desire. It has been explained to me that sometimes an anesthesia technique which involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia.

☐ General Anesthesia	Expected Result	Total unconscious state, possible placement of a tube into the windpipe
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes.
	Risks	Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, aspiration, pneumonia.
☐ Intravenous Regional Anesthesia	Expected Result	Temporary loss of feeling and/or movement of a limb.
	Technique	Drug injected into veins of arm or leg while using a tourniquet.
	Risks	Infection, convulsions, persistent numbness, residual pain, injury to blood vessels.
☐ Monitored Anesthesia Care (with sedation)	Expected Result	Reduced anxiety and pain, partial or total amnesia.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes producing a semi-conscious state.
	Risks	An unconscious state, depressed breathing, injury to blood vessels.

I hereby consent to the anesthesia service checked above and authorize that it be administered by CSA team members, physicians, or his/her associates, all of whom are credentialed to provide anesthesia services at this health facility. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by them. I expressly desire the following considerations be observed (or write “none”): _________________

I certify and acknowledge that I have read this form, or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia service and that I had ample time to ask questions and to consider my decision.

Name: ____Date: _______________

Signature: ____

Physician-Patient Arbitration Agreement

Under this practice, this Arbitration Agreement ("Agreement") should be read carefully and fully understood. If you have any questions before or after reading and signing this statement, please ask the staff or office manager. Please read this document clearly. Thank you for your consideration.

Any concern should be brought to the attention of your physician. In the extremely rare instance that conscientious evaluation of the concern and subsequent recommendation does not lead to resolution, we knowingly choose to adjudicate the dispute using binding arbitration. An arbitration agreement is intended for use in the resolution of disputes. This agreement must be completed and signed by both parties prior to entering into the agreement for surgery, so that in the event of a dispute this contract will be in place to limit the expense and time necessary for civil litigation in a court.

In consideration of this agreement, the physicians, their employees and assistants as assigned, herein called the Physician, were contracted through a consent process, consultation and recommendations, to render certain medical and elective surgical services for hereinafter named patient. Physician and the patient, do hereby agree to the following:

Article 1: In the event of any claim, demand, controversy, civil action or dispute, including but not limited to personal injury, malpractice, negligence or any tort, whether brought in tort, contract or otherwise, by Patient, his dependents, whether or not minors, heirs at law, or person representatives, against Physician or any of Physician's officers, directors, shareholders, agents, representatives, employees, successors in shareholders, agents, representatives, employees, successors in interest assigns, staff physicians or associates agreeing in writing to be bound by contract to this arbitration provision of the agreement **THE SOLE METHOD FOR RESOLVING SUCH DISPUTE SHALL BE BY BINDING ARBITRATION ADMINISTERED BY THE AMERICAN ARBITRATION ASSOCIATION** in accordance with the Commercial Arbitration Rules of the American Arbitration Association. The parties, who are the physician and the patient, shall be heard by an arbitrator who shall decide the controversy based on the evidence presented. The arbitrator will be agreed upon by mutual consent of the parties. It is agreed that all parties relevant to a full and complete settlement of any dispute subject to this agreement may be interviewed or joined.

Article 2: Any expert called or utilized in support of an expert opinion must be of similar training and experience as the physicians of contract. Only a board-certified Cosmetic Surgeon, with or without additional credentials, board certifications or degrees in maxillofacial and facial cosmetic surgery may be utilized as an expert in cosmetic surgery. Many other types of physicians exist, but this is the highest level of expertise available in the area of cosmetic surgery.

Article 3: The prevailing party in any arbitration pursuant to this agreement shall be awarded all cost, including reasonable attorney's fees and the arbitrators' fees, in prosecuting or defending the claim in arbitration, but not to exceed $2000.00 in amount. Furthermore, if any action is initiated or undertaken to set aside or otherwise attach these arbitration agreements or awards, or to compel arbitration, the prevailing party in the court action shall be entitled to all costs of such action, including reasonable attorney’s fees as may be fixed by the court.

Article 4: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this contract were unnecessary, authorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by the Florida Arbitration Code, Chapter 682, and not by a lawsuit except as Florida law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration.

Article 5: AU Claims Must Be Arbitrated: It is the intention of the parties that this Agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee /Tom the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 6: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties and must be made within the time set forth in F.S. 95.11 dealing with medical malpractice. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit Arbitration shall take place within 30 days after the completion of discovery as provided in the Florida Rules of Civil Procedure (Rules 1.2801.390) and the decision of the arbitration panel shall be binding upon all parties for all purposes. The time for responding to discovery requests shall be 10 days. All discovery shall be completed within 2 months after the appointment of the panel of arbitrators, unless the time for discovery is extended for good cause by the panel. The arbitration panel shall decide any disputes regarding discovery. The arbitration panel is expressly authorized to award all reasonable fees and costs, including attorney's fees, to the prevailing party against any party who has violated this Agreement. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law provisions. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and join in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and join any existing court action against such additional person or entity shall be stayed pending arbitration.

Article 7: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (I) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable Florida statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the Florida Rules of Civil Procedure provisions relating to arbitration.

Article 8: Retroactive Effect: If patient intends this Agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should sign below.

Effective as of the date of first medical services Patient's or Patient's Representative's signature.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and effect and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this Arbitration Agreement.

Name: ____ Date: ____

Signature: ____

FAQ's: QUESTIONS YOU MIGHT HAVE IN PREPARATION FOR YOUR SURGERY

Do I need to see any other doctor before my surgery?

After review of your medical history, a recommendation specific to your history and the type of surgery will determine if your physician requires additional tests such as blood work, ECG, mammograms, etc.

What paperwork needs to be filled out before my surgery?

All consents that include procedure specific consents, anesthesia consents, privacy policy, use of photos consent and arbitration agreements. These are documents you sign after discussing benefits, risks, and alternatives to surgery with your surgeon.

FMLA/Leave of Absence Forms: Please let our office know if you need any forms filled completed in advance of your recovery. Additional fees may apply.

Do I need to identify a contact person (patient coach) before my surgery?

Your caregiver should be present on the day of your discharge when you receive final discharge information from the care team.

How do I manage my medications before surgery?

If you are taking **blood thinners** such as Plavix (Clopidogrel), Coumadin (Warfarin), Pradaxa (Dabigatran), Rivaroxaban (Xarelto) or Apixaban (Eliquis), please contact your surgeon's and PCP's office as you may need to stop taking these medications. Your surgeon and PCP will then need to work together for optimal management of these medications:

Diabetes medications Please contact your PCP for instructions because you may not need these medications the morning of your surgery.

Blood pressure medications If you take this in the morning, take it with only a sip of water the morning before surgery.

Aspirin or Aspirin Related Products

Over the counter: Alka Seltzer, Aspirin regimen Bayer, Ecotrin, Excedrin or Excedrin extra strength, Momentum Backache Relief, Vanquish Analgesic Caplets

Prescription: Easprin, Disalcid, Plavix, Salflex, Trilisate

Non-steroidal analgesics (NSAIDS)

Over the counter: Advil, Aleve, Motrin, Nuprin, Orudis KT

Prescription: Mobic (Meloxicam), Celebrex, Anaprox Nalfon, Arthrotec Naproxyn, Cataflam Oruvail, Clinoril Ponstel Kapseals, Daypro Relafen, Disalcid Salflex, Ec-Naproxyn Tolectin, Feldene Toradol, Indocin Trilisate, Lodine Voltaren

Herbs

Echinacea, St. John's Wort, Ephedra, Valerian, Feverfew, Vitamin E, Fish Oil, Vitamin C, Garlic, Gingko Biloba, Ginger, Ginseng, Green tea, Kava, Vitamin E

Diet Pills

Including but not limited to Phentermine, Reduz, Ephedra (any type) and both prescription and over the counter diet pills.

Hormones

Including but not limited to Estrogen and Testosterone should be stopped 2 weeks prior to surgery**.**

Smoking

Cigarettes, vapes and marijuana need to be stopped 2 weeks prior to surgery and continued to be avoided for at least 2 weeks after your surgery. This is to ensure you have optimal healing.

If you are unsure if your medication(s) should be stopped, please consult with our nurse.

*****It is imperative that we have a current detailed medication list with doses & directions as well as any allergies.**

Is there any special skin preparation before surgery?

DO NOT SHAVE the surgical area for three days before surgery, as this can leave small openings in the skin which can be entry points for bacteria.

An antiseptic skin cleanser liquid called Hibiclens (chlorhexidine gluconate) is recommended. **Be careful not to get Hibiclens soap in your eyes, nose, ear canals or mouth. Hibiclens is for use below the chin only.**

Please avoid any lotions, deodorant and creams on the skin the day of surgery.

Have any fake nails removed before day or surgery, and long nails should but cut short.

When is the last time I can eat or drink before surgery?

Do not eat anything (including chewing gum or candy) after midnight or at least 8 hours prior to your surgery check-in time. You may ONLY have sips of clear liquids (water, Pedialyte, or Gatorade) as needed to take medications for 4 hours prior to surgery.

PRIOR TO YOUR SURGERY DATE

<u>What do I do if I feel sick before surgery?</u>

Please notify us immediately if you have developed any type of illness or infection (flu, cold, fever etc.) We would also like to know if you have an open sore, rash or skin irritation near the surgical site.

<u>Is the planned surgery start time always correct?</u>

If your surgery is not the first scheduled operation of the day, your surgery start time may be earlier or later than planned. If this does occur, you will be informed.

<u>What do I bring to the facility?</u>

To avoid lost or misplaced personal items, we recommend that you bring only essential items to the facility such as glasses. Leave jewelry at home. Loose, comfortable fitting clothing, no jeans. If applicable, bring any inhalers you may use if needed on a regular basis.

THE DAY OF YOUR SURGERY

<u>Where do I check in?</u>

Check in on the day of your surgery through our Surgery Center Check-In entrance located on the North side of our building.

<u>Where will I go after I check in?</u>

When your admission process is completed, a staff member will bring you to a room where you will get changed, a urine sample will be obtained, and you will meet with your surgeon.

Your caregiver will be escorted to the front lobby and staff will keep your designated person informed.

<u>What happens immediately after the surgery is completed?</u>

Following surgery, you will go to our main recovery area, PACU (Post-Anesthesia Care Unit). You will be closely monitored in PACU, until ready to go home or transferred to an inpatient room. While in PACU, a nurse will always be with you monitoring your progress.

Recovery times vary from patient to patient. Once you have been stabilized, a nurse will notify your loved ones that they may see you.

What To Expect After Surgery

What appointments will I have?

Follow-up protocol is 24 hours, 1 week, 2 weeks, 1 month, 3 months, 6 months and as needed. While we do ideally prefer to see you in the office for your follow-up visits, we do understand that some travel far to see us and must return home. We do allow photo follow-ups through our safe, data-encrypted email that are uploaded to your chart. We highly encourage you to stick with the follow-up protocol should you need to go this route. Your happiness, confidence and perfection of our work is of the upmost important to us, and we want to ensure that by keeping in contact as we do with all our patients.

What about my incisions?

Keep your incision clean and dry at all times.

When showering, please be gentle on the skin around the incision and allow the scabs to fall off themselves. No soaking in hot tubs, baths, swimming pools, or Jacuzzi until your incision is completely healed.

Please read your Post-op Instructions before your surgery so that you know what to expect. If you have any further questions, please do not hesitate to contact us at 904-648-6400.

We wish you a speedy recovery!

Smoking Consent

We strive to offer the finest surgery available and most predictable outcomes for our patients. Smoking significantly increases the risks associated with poor outcomes in all types of surgery. As a result, we request that all patients who smoke quit for at least two weeks prior to surgery and remain smoke free for at least two weeks after surgery. This minimizes the risks of poor wound healing, increased scarring, and need for further surgery. A history of smoking is always a cause for caution when choosing an elective surgery and those risks cannot be eliminated, only reduced by this protocol.

This above statement has been read, completely understood and your questions have been answered regarding the well-known risks of smoking and poor outcomes for surgery of any kind. This statement acknowledges your acceptance of all costs related to the increased risk of complications due to smoking. These may include additional surgery, cost of medications, creams, lotions, antibiotics, hospitalizations, or consultations with additional physicians including hyperbaric oxygen treatment. Your signature below acknowledges this discussion, our recommendations, and your understanding of those increased risks of a poor outcome.

Name: ____ Date: ____

Signature: ____

Revision Policy

There is extreme variation in the healing process among all patients. Due to the uncertain nature of healing, a patient may elect to have additional surgery performed to modify results of their original surgery for better results and increased patient satisfaction. As in all surgery, both the physician and patient must mutually agree that a revision procedure could further improve the initial results and that the benefit of such a revision would outweigh the risks.

- There will be a **minimum charge of $1,500** for the use of the facility, staffing, supplies, anesthesia, and materials to perform revision surgery within the first year following your primary procedure.
- Additional fees may be appropriate and will be individually determined in consultation.

At no time will this agreement constitute an admission of guilt or responsibility.

No surgical procedures will be scheduled without receiving our predetermined fee.

This policy has been presented at the time of consultation to inform patients more fully and to limit uncertainty of possible charges in the future. We feel this is an extremely generous offering and consider it part and proof of our efforts to provide patients with the highest level of care.

Examples:

- Undesirable scarring
- Breast asymmetry
- Areolar shape
- Capsular contracture
- Dog ear formation
- Irregularity after liposuction
- Modification of the shape or position of the belly button
- Nasal irregularities
- Airway compromise

Name: ____ Date: ____

Signature: ____

Photography & Video Consent

Please read and acknowledge understanding and approval of the following:

____ I consent to the taking of photos, slides, or video footage by the physicians at Cosmetic Surgery Affiliates (CSAJAX), or their designees, of me or parts of my body in connection with the cosmetic surgery procedure(s) to be performed by the physicians at CSAJAX. I provide this authorization as a voluntary understanding that photographs are a mandatory part of documentation and may be the best method of evaluation of results of all forms of documentation.

____ I understand that such photographs shall become the property of Cosmetic Surgery Affiliates (CSAJAX) and may be retained by CSAJAX or released by CSAJAX for the purpose of including them in any print, visual, or electronic media, specifically including, but not limited to websites, medical journals and textbooks, for the purpose of informing the medical profession or the general public about cosmetic surgery procedures and methods.

____ Neither I, nor any of my family, will be identified by name in any publication. I understand that in some circumstances, the images may portray features that make my identity recognizable.

____ I understand that I may refuse to the authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information but will not affect the healthcare services I presently I receive, or will receive, from the physicians at CSAJAX.

____ I understand that I have the right to inspect and copy the information that I have authorized to be disclosed and that I will be charged an additional fee if chosen. 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 release and discharge the physicians at CSAJAX and all parties acting under his 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 publication of the photographs.

PLEASE CHOOSE ONE OF THE FOLLOWING TWO OPTIONS:

- OPTION 1- I fully understand and consent to the above Agreement and Release as written.
- OPTION 2- I fully understand and consent to the terms of the Agreement and Release written above, however**, I DO NOT wish to have my photographs/images used for print or digital media, or for publication in medical journals or textbooks at this time.**

Name: ____ Date: ____

Signature: ____