MARYLAND PLASTIC SURGERY
AT THE AESTHETIC INSTITUTE

Welcome to our facility! We know that you have many options when selecting a plastic surgeon or skin care specialist and we are pleased that you have chosen Maryland Plastic Surgery and PURE MedSpa at The Aesthetic Institute. Our team of plastic surgeons, skin care specialists, nurses, and technicians are experienced in plastic surgery, dermatology, non-surgical face and body rejuvenation, cosmetic laser procedures, minimally invasive cosmetic surgery, and complete surgical "make-overs".

During each visit, we are committed to providing you with the best possible care. To help us achieve this goal, please complete each of the attached pages in their entirety. Please note that your signature is *required* on each of the following pages:

- Financial Agreement
- Photographic Consent
- Privacy Policy

We know that patients frequently must wait to be seen when visiting with physicians. Please note that we respect your time and attempt to minimize your wait. Although we do not "double book" patients, you may be asked to wait if another patient requires extra time. In the event of an unexpected delay, we will make every effort to accommodate your busy schedule with a choice of alternate consultation times or dates.

We hope that your visits with us are both comfortable and educational. Our goal is to provide exceptional care and service. To achieve this goal, we request that you provide us with your comments – feedback forms are available for this purpose.

CHILDREN ARE NOT PERMITTED

***** THE FACILITY IS FOR ADULTS ONLY *****

To maintain a tranquil atmosphere in our office, we request that you set your cell phone to silent/vibrate mode and avoid having loud conversations as other patients are receiving treatments. If you are accompanied by family or friends, one individual may join you during your consultation.

We look forward to meeting you and helping you achieve your goals.

Maryland Plastic Surgery

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FINANCIAL AGREEMENT

PAYMENT FOR SERVICES:

I agree that I am personally responsible for prepayment of all services. If I am not asked to prepay for a service I receive, I agree to pay in full immediately upon receiving notice that a payment is due. I understand that surgical procedures will not be scheduled until I either pay the reservation fee or verification of financing is accepted. I will pay any balance due at least one month prior to the day of surgery or my surgery date will be rescheduled. I understand that: additional services may be required to achieve my goals; payments are made for the provisioning but not performance of specified service(s); and there is no promise or guarantee regarding any outcomes.

OWNERSHIP / CERTIFICATION:

I understand that the Maryland Plastic Surgery Center is a State licensed Ambulatory Surgery Center with Medicare certification. Maryland Plastic Surgery, LLC is owned and operated by Adam Summers, M.D.

REFUND POLICY:

I understand that any payments I make are non-refundable. However, if I cancel any service, I may use the balance of funds for other services at the Maryland Plastic Surgery Center and PURE MedSpa (the "Company"). Balances are calculated from the amount paid less the regular/list price of each treatment, less any special pricing (discounted, rebated, "package", or otherwise), and less any rebooking or other cancellation fees. Because prior discounts do not apply, a negative balance may result. If my procedure is canceled due to my non-compliance (eg. if I smoke) I will not be entitled to any refund.

INSURANCE PAYMENTS:

I understand that the healthcare providers at the Maryland Plastic Surgery Center do not accept *any* form of third party reimbursement or health care insurance. I understand that I may request a printed statement which I may personally submit to my insurance company for reimbursement, but there is no guarantee of any reimbursement.

MEDICARE: I understand that Medicare will reimburse 80% of the allowed amount of the facility fee. This does not include any professional service fees. I agree to personally pay for services rendered and balances due on the allowed amount. Maryland Plastic Surgery, LLC or its assign(s) may apply for benefits on my behalf for rendered services with payment made directly to the party accepting any assignment.

COLLECTIONS / FEES / CHARGES:

I agree that if I: (1) breach this Agreement or any other agreements I make with the Company or providers; or (2) I forfeit or lose, in whole or in part, any legal action (demand, arbitration, litigation, or otherwise); then I will pay the Company, without limitation: (1) all charges necessary to cure each breach; (2) all costs incurred by the Company (including collections fees, attorney fees, court fees, accrued interest, etc.); and (3) professional fees ($1000/hr) for time spent by the Company and/or its providers in the preparation and defending of the action. I authorize the conversion of my check(s) to an immediate debit via electronic funds transfer. I authorize the re-submission of all checks returned for either insufficient or uncollected funds plus $50 and any fees associated with each returned/unpaid check. My account will accrue interest charges at the maximum allowable rate on unpaid balances.

I Have Read This Entire Agreement And I Understand And Agree To All Of The Above.

Signature of Patient or Legal Guardian Printed Name Date

MARYLAND PLASTIC SURGERY
AT THE AESTHETIC INSTITUTE

MEDICAL RECORD AND PRIVACY POLICY

During your visit with us, we create a medical record that contains detailed nonpublic personal information. The medical record is compiled from information: (1) provided to us by you, your family and caregivers; (2) obtained by us with your authorization; (3) provided to us by other health care professionals; and (4) created by us. *You agree that this medical record is the property of Maryland Plastic Surgery, LLC*. We protect our medical records using physical, electronic and procedural safeguards complying with our professional standards.

We do not disclose any medical record except as required or permitted by law. Permitted disclosures include, for instance, providing information to our employees and to third parties who need to know that information to assist us in providing services to you. Such third parties include, for example, transcription services, laboratories, medical facilities, health care providers and insurance companies. We will provide a copy of the medical record, or portions thereof, on written request by another healthcare provider or attorney only with your prior written consent for the release of specific information. We will provide a copy of the medical record, or portions thereof, to a court if so required by law. Except as otherwise required by law, you have the right to request in writing that we limit disclosure of the medical record (a Privacy Form is available for this purpose). You agree that we may place a copy of any information you supply to us in the medical record.

Digital services are used to create portions of the medical record, including photographs and dictations. You authorize the use of photographs obtained as detailed in the Photographic Consent form. Dictations and photographs are stored in multiple files and may not be transcribed and/or printed unless a hard copy is needed. Therefore, any requests for copies of the medical record may take up to 30 days to assemble. You agree to pay a fee for copies of the medical record which include transcription costs and fees allowable by statute, including fees for preparation, photocopying and mailing, as applicable. We will prepare a summary of the medical record if so requested by you or your attorney and after receipt of document preparation fees.

You may request to review the medical record. This is done on an appointment basis at which time you may request that we make any corrections or clarifications of the record if you so desire.

In order to facilitate your health care, you specifically authorize us to utilize and transmit the medical record as noted above without limitation and as we may deem necessary in our sole opinion unless otherwise limited by you in writing. You indemnify us and hold us harmless from any use or transmission of the medical record.

Occasionally, we may contact you or notify you regarding your appointments, account balance, product or safety updates, and information regarding the practice. You specifically authorize these contacts without limitation unless you have otherwise informed us in writing (a Privacy Form is available for this purpose). However, you may **not** opt-out of appointment reminders made by our automated system. Finally, you agree that any portion of your consultation may be recorded for quality assurance without the need for us to obtain any additional consent.

Your signature below indicates that you understand and agree to our Medical Record and Privacy Policy.

Signature of Patient or Legal Guardian Printed Name Date

MARYLAND PLASTIC SURGERY
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PHOTOGRAPHIC CONSENT

I authorize the Maryland Plastic Surgery & PURE MedSpa staff to take photographs of me before, during and after any consultation, treatment or procedure provided. I understand that the photographic documentation is a necessary and required part of my clinical and surgical records. Photographs may be transmitted in compliance with the Company's Medical Record and Privacy Policy which I have signed. I agree that photographs that do not contain personally identifiable information may be used for patient education and practice marketing without restriction. I agree that any photographs may be used in conjunction with certification examinations and quality assurance surveys by accredited agencies.

Additionally, I consent to the use of photographs which may contain personally identifiable information and accompanying records for the following purposes:

- On display in and around the office
- In online and broadcast video
- On website photo galleries
- In printed materials

I have crossed out and initialed the sections above where I do not give my consent.

I release and forever discharge the Company, including its affiliated companies, owners and staff from any and all liability resulting from the use of photographs for any of the above authorized purposes. I understand that I will not receive any remuneration, in any form, if photographs are used for any purpose.

I may revoke use of photographs containing personally identifiable information by submitting such request in writing at any time but I agree that the revocation will not become effective until I have obtained a written acknowledgement that the revocation has been received by Maryland Plastic Surgery. Items disseminated prior to revocation will not be removed or retrieved from online, broadcast, or printed sources.

If the patient noted above is a minor or unable to sign, I am the legal guardian of the patient. A witness signature is required if I am signing in-lieu of the patient. I have received a copy of this signed consent if I have so requested.

Signature Printed Name Date

Witness Signature Witness Printed Name

Members
AMERICAN SOCIETY OF PLASTIC SURGEONS

MARYLAND PLASTIC SURGERY
AT THE AESTHETIC INSTITUTE

Today's Date: _____

PATIENT REGISTRATION

Patient's Full Name: _____ Gender: Male Female
First MI Last Suffix

Home Address: _____ Soc Sec # _____
Street

_____ Date of Birth: _____
City State Zip

Contact Numbers: ( ) _____ ( ) _____ ( ) _____
Home Phone Work Phone Cellular Phone or Pager

E-mail Address: _____ Marital Status: S M W D

Spouse: _____ Phone: _____

Emergency Contact: _____ ( ) _____ Relation: _____
Name Telephone

Referral Source: _____
How Did You Learn About Us? Primary Physician

BACKGROUND INFORMATION

Occupation: _____

Employer Name: _____ Work Phone: _____

SPECIFIC DESIRES / CONCERNS

Desires/Concerns: _____

My budget to achieve my desires is: □ <$5,000 □ $5,000-$10,000 □ $10,000-$20,000 □ $20,000-$30,000 □ >$30,000

INTERESTS

NON-SURGICAL

- □ Fractional Laser Resurfacing
- □ Treat Active Acne / Problem Skin
- □ Laser Hair Removal
- □ FotoFacial / Intense Pulsed Light
- □ Laser Sclerotherapy (Spider Vein Removal)
- □ Cellulite Treatment
- □ Injectable Fillers
- □ Botox® Injections
- □ Microdermabrasion
- □ Tighten Wrinkles
- □ Erase Fine Lines
- □ Shrink Acne Scars
- □ Remove Red Spots
- □ Remove Brown Spots

SURGICAL

- □ SMART Facelift
- □ Facelift (Mini or S-lift)
- □ Necklift
- □ Ear Setback
- □ Nose Job (Rhinoplasty)
- □ Liposuction
- □ Eyelid Lift
- □ Lip Enhancement
- □ Browlift
- □ Breast Lift
- □ Breast Implants
- □ Breast Reduction
- □ Body/Thigh/Arm Lift
- □ Tummy-tuck

SPECIALTY

- □ Laser Facelift
- □ One Hour Facelift
- □ Laser Liposuction
- □ Micro Liposuction
- □ Rosacea Treatment
- □ Endermologie
- □ Laser Body Contouring
- □ Weight Management
- □ Bio-Identical Hormones
- □ Laser Vaginal Tightening
- □ Erectile Dysfunction Rx
- □ Breast Aug w/o Impants

MARYLAND PLASTIC SURGERY
AT THE AESTHETIC INSTITUTE

Name: _____

Today's Date: _____

CONFIDENTIAL QUESTIONNAIRE

Consult for: ▫ Face ▫ Breast ▫ Body ▫ Skin **Preference:** ▫ Surgical ▫ Non-Surgical

Specific Reason for Consult: _____

_____

DESCRIPTION OF YOUR CONCERN / PROBLEM: Please list each of your concerns in as much detail as possible. Include the date when the concern first became apparent.

_____

_____

_____

ALLERGIC REACTIONS: Do *not* include seasonal allergies (e.g. hayfever, pollen).

DRUG ALLERGY (e.g. Penicillin, Sulfa)	REACTION

LATEX ALLERGY: ▫ Yes ▫ No

MEDICATIONS: Include all prescription medications, over-the-counter medications (e.g. aspirin, ibuprofen), vitamins and herbal supplements (e.g. Echinacea, St. John's Wort). Continue on a separate sheet, if necessary.

MEDICATION	Dose (mg)	Times Daily	Date Started

Omega-3 Fish Oil, Flax Seed, or Turmeric: ▫ Yes ▫ No

SURGICAL PROCEDURES & HOSPITALIZATIONS: List all surgeries, ER visits, and hospitalizations.

Date	Hospital	Reason for Hospitalization	Physician

MEDICAL HISTORY:

	Date Diagnosed	Details
Anesthesia Difficulties		
Cancer – (Skin, Breast, Other)		
Connective Tissue Disorder		
Diabetes		
Digestive Disorder		
Glaucoma		
Heart Disease		
High Cholesterol		
High Blood Pressure		
Immune Disorder (HIV, Lupus, Myasthenia)		
Kidney Disease		
Liver Disease (Hepatitis)		
Lung Disease (Asthma, Emphysema)		
Muscle Disease / Weakness		
Psychiatric (Bipolar, Schizophrenia)		
Radiation Therapy (list site)		
Sleep Apnea		
Skin Lesions		
Other:		

FAMILY HISTORY:

Children (age & sex): _____ (M/F) _____ (M/F) _____ (M/F) _____ (M/F) _____ (M/F)

	Father	Mother	Grandparent	Sibling	Children
Bleeding Disorder					
Cancer – Breast					
Cancer - Skin					
Cancer – Other:					
Connective Tissue Disorder					
Diabetes					
Heart Disease					
Malignant Hyperthermia					
Other:					

SOCIAL AND WELLNESS HISTORY:

With whom do you live?	▫ Alone	▫ Spouse	▫ Friend	▫ Parent/Children
Have you ever been a party to a lawsuit?	▫ No	▫ Civil Matter	▫ Malpractice	▫ Other
In general, your anxiety level is:	▫ Low	▫ Medium	▫ High	

Tobacco use (typical): _____ Packs/day Years of use: _____

Alcohol use (average): _____ Drinks per ▫ Day ▫ Week ▫ Month

Comment on any recent weight gain / loss: _____

Describe your exercise program and regularity: _____

List your hobbies: _____

REVIEW OF SYSTEMS: Please check each box that applies to you.

Gastrointestinal /Genitourinary
- ▫ Loss of appetite
- ▫ Stomach ulcer
- ▫ Constipation
- ▫ Diarrhea
- ▫ Bloody stool
- ▫ Nausea
- ▫ GI pain
- ▫ Difficulty urinating
- ▫ Incontinent (bowel / bladder)

Breast
- ▫ Nipple discharge
- ▫ Breast pain
- ▫ Breast lump(s)
- ▫ Uneven breasts

Cardiopulmonary
- ▫ Chest pain
- ▫ Shortness of breath
- ▫ Wheezing
- ▫ Pneumonia
- ▫ Tuberculosis
- ▫ Palpitations

Cutaneous
- ▫ Cold Sores
- ▫ Acne / Cysts
- ▫ Accutane used

Orthopedic
- ▫ Broken bones
- ▫ Arthritis / Joint pain

Psychological and Dependency
- ▫ Anxiety or Depression
- ▫ Sexual abuse
- ▫ Alcoholism
- ▫ Substance abuse

Neurologic
- ▫ Seizure
- ▫ Migraine headaches
- ▫ Weakness
- ▫ Vision changes
- ▫ Auditory changes

Other
- ▫ Easy bruising or bleeding
- ▫ Infections

COMMENTS: Please note any other comments you have that will help us provide you with the best possible care.

_____

_____

_____

_____

_____

_____