1. PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.

I hereby give my consent for **Pierini Esthetic Surgery Center** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Pierini Esthetic Surgery Center** describes such uses and disclosures more completely.). I have the right to review the Notice of Privacy Practices prior to signing this consent. Pierini Esthetic Surgery Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Pierini Esthetic Surgery Center.** With this consent, **Pierini Esthetic Surgery Center** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others. With this consent, **Pierini Esthetic Surgery Center** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential." With this consent, **Pierini Esthetic Surgery Center** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Pierini Esthetic Surgery Center restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to allow **Pierini Esthetic Surgery Center** to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Pierini Esthetic Surgery Center** may decline to provide treatment to me. **PATIENT/GUARDIAN MUST BE PROVIDED WITH A SIGNED COPY OF THIS AUTHORIZATION FORM.**

Acknowledge_____(initial)

2. PATIENT INFORMED CONSENT.

Under Florida Law, medical offices with fully equipped Operation Room are regulated to the rules of the Board of Medicine as set Forth on Rule Chapter 64B 8, F.A.C. This notice is provided pursuant to Florida Law.

RECEIPT OF NOTICE OF PRIVACY PRACTICE. WRITE KNOWLEDGE FORM.

I_____(PATIENT) have read a copy of Pierini Esthetic Surgery , notice to patients practices.

Acknowledge_____(initial)

3. INSURANCE DISCLOSURE.

"Under Florida Law", Physicians are generally required to carry Medical Malpractice Insurance, or otherwise demonstrates financial responsibility to cover potential claims for Medical Malpractices. **YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE**. This is permitted under Florida Law subject to certain conditions. Florida Law imposes penalties against noninsured physicians who fail satisfy adverse judgments arising from claims of medical malpractice. "This notice is provided pursuant to Florida". THIS UNDERSIGNED HAS BEEN FULLY INFORMED ABOUT THIS MATTER Acknowledge_____(initial)

4. NICOTINE AND TOBACO WARNING.

The Nicotine in Tobacco Products constricts the blood vessels of your body. This effect is immediate and lasts up to three weeks. This may affect the circulation of tissues handled during surgery resulting in necrosis (dead tissue) delay in healing, and infection. This may result in an open wound that may take months to heal and leave a significant scar and deformity. You should STOP SMOKING, using a nicotine patch, chewing nicotine gum or use of any other tobacco product for at least three weeks prior to and three weeks after your surgery. This is very important if we want to obtain an optimal surgical result.

I have read and understand the risks, complications and adverse affects associated with the use of tobacco products prior and after the surgery. If I decide to smoke either prior to or after my surgery; I take full responsibility for all complications related to my use of tobacco. Acknowledge_____(initial)

5. PATIENT/VISITOR VIDEO MONITORING.

POLICY:

a). The facility prohibits, except when emergency circumstances require otherwise, a staff member attending a patient in the recovery room, unless the staff member is authorized to attend the patient in the recovery room and is in the company of at least one other person.

b). In accordance with F.S. 59A-5 "Ambulatory Surgery Licensure", Ambulatory Surgery Centers (ASCs) are exempt from the two-person requirement if it has: Live visual observation, Electronic observation, Any other reasonable measure taken to ensure patient protection & privacy

LIVE VISUAL OBSERVATION VIA VIDEO ELECTRONIC MONITOR:

Patient video electronic monitoring is authorized in Operating and Procedure Rooms and PACUs, to meet patient and staff concerns against sexual misconduct incidents or accusations. Other visual monitoring of Center areas for security purposes is limited to entrances, waiting rooms, corridors, stairwells etc, which are consider public and thus expectations of privacy is not expected nor guaranteed. In other areas were patient care is rendered outside of the OR's PACUs and Procedure rooms, such as exam or conference rooms, video taping is prohibited unless written informed consent is obtained from the patient.

In areas were video monitoring is prohibited, the two person rule must be observed:

- Chaperone protocols will be observed at all times. No patient will be attended by the opposite sex without another staff member present or via video electronic monitoring.
- No patient should be left attended alone with one staff member
- There must always be two persons unless electronic monitoring as outlined above is met.

I _____ hereby certified that I have read and understood the above policy stating the existence of surveillance equipment for security and patient safety reasons. Furthermore, I understand that I am signing this as a written informed consent for the use of such equipment in all areas were patient care is rendered outside of the OR's PACUs and Procedure rooms, such as exam or conference rooms. Acknowledge_____(initial)

6. PATIENT-DOCTOR ARBITRATION AGREEMENT.

This Agreement is made between Dr. Stephanie Stover, and his employees, agents, and servants (hereinafter collectively referred to as "Doctor") and _____ (hereinafter referred to as "Patient"). It is the intention of the parties to this agreement to bind not, only themselves but also their, heirs, personal representatives, guardians or any persons deriving their claims through or on behalf of the Patient.

It is understood by the Patient that he or she is not required to use the Doctor listed above for plastic surgical services, plastic surgery and cosmetic surgical services ("Services"). The Patient also understands that there are numerous other physicians and facilities in this area who are qualified to render quality Services and the Doctor is willing to refer the Patient to another physician or facility in the area of those Services if the Patient requests. Both the Doctor and the Patient agree that arbitration is a preferable method to solving any disputes they may have in connection with the Services, and wish to avoid the expense and inconvenience of litigation, whether by judge alone or by jury.

It is mutually agreed that any controversy, dispute or claim arising out of or relating to the Services of any kind, including the medical care rendered or payment of medical or surgical fees, or any other matter whatsoever, including the interpretation, hereof, shall be settled by arbitration in accordance with the Florida Arbitration Code. The controversy or claim, shall be submitted to a single arbitrator (a Board Certified Plastic and Reconstructive Surgeon and a member of ASPS licensed to practice medicine in the State of Florida) mutually agreed upon by the parties within thirty (30) days of notice of an intent to arbitrate any matter hereunder. If the parties cannot agree upon an arbitrator within such thirty (30) day period such an arbitrator shall be selected in accordance with the Florida Arbitration Code through a court, which has a situs in Miami-Dade County, Florida. The arbitration of such dispute will be held in Miami-Dade County, Florida within thirty (30) days after completion of discovery. The award of the arbitrator will be final and binding on all parties to the arbitration and judgment may be entered upon it in accordance with law in any court of competent jurisdiction. In the event of arbitration the parties hereto specifically agree that discovery shall be allowed in the form of written interrogatories, depositions of witnesses, production, inspection and copying of documents to the same extent as is provided under the Florida Rules of Civil Procedure. Provided, however, the time for responding to requests for written interrogatories, production and inspection and copying of documents shall be reduced to ten (10) days. Any disagreement between the parties to the dispute as to the scope and extent of and compliance with the discovery will be referred to the arbitrator and his or her determination shall be final. The parties further agree that such discovery procedures shall not be extended beyond two (2) months from the selection of the arbitrator; provided, however, that for good cause, the arbitrator shall be permitted in his or her discretion to extend said time for discovery. All expenses of the arbitrator and arbitration (exclusive of each party's attorneys fees, if any) shall be borne equally between the Patient and the Doctor. Provided, further, the parties hereto agree that no punitive damages may be awarded. Should any part of the provision of this Agreement be held unenforceable or in conflict with law, the validity of the remaining parts or provisions shall not be effected by such holding. This agreement shall remain in effect for all treatment, services and surgery provided to the patient presently and any future dates. I (we) have set our hands this _____day of_____,20_____.

DOCTOR:

By:_____

I hereby acknowledge that I have read this forms and I understand its contents and agree to all of the provisions contained herein, which I agree shall be applicable to any and all care and treatment provided by Pierini Esthetic Surgery Center.

Patient Signature: _____ **Date:** _____

Print Patient's Name: _____ **Witness Signature**: _____

Print Name of Legal Guardian, if applicable: _____