J. SWEAT
PLASTIC SURGERY

Patient Name:_____ **Phone #:** _____

Pre-Op Date:_____ **Arrival Time:**_____
Surgery Date:_____ **Arrival Time:**_____
Post-Op Date:_____ **Arrival Time:**_____

Patient Agrees to the Following Procedures:

❑ Body Procedures:
- ❑ Tummy Tuck
- ❑ Mini-Tummy Tuck
- ❑ Arm Lift
- ❑ Body Lift
- ❑ Thigh Lift
- ❑ Natural Fat Transfer

Areas:_____
_____
_____
_____

- ❑ Brazilian Butt Lift
- ❑ Labiaplasty
- ❑ _____
_____

❑ Face Procedure:
- ❑ Face Lift
- ❑ Liquid Face Lift
- ❑ Neck Lift
- ❑ Eye Lift
- ❑ Otoplasty
- ❑ _____

❑ Breast Procedures:
- ❑ Augmentation
- ❑ Breast Lift
- ❑ Breast Reduction
- ❑ _____

❑ Anesthesia Plan:
- ❑ Local
- ❑ IV Sedation
- ❑ General
- ❑ _____

❑ Liposuction:
- ❑ Upper Abdomen
- ❑ Lower Abdomen
- ❑ Axilla
- ❑ Mons
- ❑ Hips
- ❑ Flanks
- ❑ Lateral Back
- ❑ Chin
- ❑ Neck
- ❑ Arms
- ❑ Inner Thigh
- ❑ Outer Thigh
- ❑ Gynecomastia
- ❑ Sacrum
- ❑ _____

Total Surgery Cost: $_____
Less Reserved Procedure Date Deposit: $_____
Balance Due: $_____

- **Cancellation Fee:** Any cancellation prior to scheduled surgery will incur a $1000.00 fee.
- Cancellation 7 days or less from your surgery date will result in 50% loss of all fees.
- Cancellation 1 day or less from your surgery date will result in 100% loss of all fees.
- **Rescheduling fee:** Rescheduling within 14 days of scheduled surgery will incur a $1000.00 fee.
- **Balance must be paid in full 3 weeks prior to surgery.**
- **Not included with surgery fee:** Lab work (if applicable) Medical clearance (if applicable) and prescription medications.
- **Revisions:** Additional costs may be assessed in the unlikely event that revision surgery is required. Please refer to revision policy for more details.

I have read the above items and fully understood the fees as well as my financial obligation set forth herein.

Patient Signature:_____Date:_____

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REVISION POLICY

Every surgeon has a few patients who will require revision or have some unforeseen complications requiring additional surgery. When it comes to revisions, although good results are expected after plastic surgery, guarantees cannot be made regarding your final outcome. In cosmetic procedures there are certain problems that will happen statistically, no matter how excellent the care or how careful the doctor and team. Because of factors outside the surgeon's control, surgical revision may be required.

Reasons beyond our control for suboptimal results may include for example:

- A person's inherent poor healing ability. For example, tendency to form keloid scars or thick scars, irrespective of the plastic surgical closure.
- Environment or lifestyle issues such as smoking, alcohol, or drug use, or excessive sun exposure which can negatively impact the result.
- Failure to comply with post-operative instructions including activity restrictions or usage of compression garments, and follow up instructions/care.
- Failure to treat the surgical site as instructed.
- Poor skin tone or severe skin laxity which can lead to recurrent sagging or tissue stretch and thinning.
- Weight fluctuation or pregnancy after surgery.
- Gravitational effects.
- Poor circulation which can lead to delayed healing, open wounds, or skin loss.
- Metabolism of underlying suture material with suture infections or suture spitting.

In our practice, if a surgical revision is deemed necessary, the surgeon's fee may be reduced or waved if the surgeon agrees that you have a legitimate and realistic concern and the outcome is less than satisfactory to **BOTH** the patient and the surgeon. **In any revisionary procedure, the patient is always financially responsible for all outside charges including operating room fees, anesthesia fees, implant or garment fees, and supply fees.** If the revision can be done under local in the office rather than returning to the OR, in most circumstances no additional fee will be charged.

The vast majority of patients do not require additional surgery and we hope that no complication arises and no revision surgery is necessary in your case. However, no surgeon can guarantee this to patients. It is important for the patient undergoing an elective surgical procedure to understand this reality, risk and financial policy. If you have any questions regarding this policy, the office staff would be happy to discuss it with you.
My signature below, indicates that I understand and agree to the above policy.

Patient Signature _____ Date:_____

Witness:_____ Date:_____

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SUGERY CANCELLATION POLICY

YOUR SURGERY WILL BE CANCELLED, (EVEN ON THE DAY OF SURGERY) FOR ANY OF THE FOLLOWING REASONS:

(please initial below)

*YOUR PRESCRIPTIONS HAVE NOT BEEN FILLED _____

*YOU DO NOT HAVE A RIDE HOME _____

*YOU DO NOT HAVE A CARETAKER FOR THE FIRST 24 HOURS AFTER SURGERY _____

*YOUR MEDICAL CLEARANCES ARE NOT COMPLETED AND RECEIVED BY J SWEAT PLASTIC SURGERY CENTER AT LEAST ONE WEEK PRIOR TO SURGERY (if applicable) _____

*YOUR REQUIRED LABS ARE NOT COMPLETED AND RECEIVED BY J SWEAT PLASTIC SURGERY AT LEAST ONE WEEK PRIOR TO SURGERY _____

*YOU HAVE HAD FLUIDS/FOOD AFTER MIDNIGHT OR 8 HOURS PRIOR TO YOUR SURGERY ARRIVAL TIME _____

*MEDICATIONS WERE NOT TAKEN AS INSTRUCTED BY YOUR DOCTOR _____

*YOU TEST POSITIVE FOR NICOTINE _____

*YOU HAVE NOT STOPPED BLOOD THINNING MEDICATIONS SUCH AS COUMADIN, ASPIRIN, BUPROFEN, ETC. ONE WEEK PRIOR TO SURGERY AS INSTRUCTED BY YOUR DOCTOR _____

*YOU HAVE AN OUTSTANDING BALANCE WITH J.SWEAT PLASTICS THAT IS NOT PAID AT LEAST THREE WEEKS PRIOR TO SURGERY _____

*If surgery is cancelled within 1 week of the scheduled procedure, 50% of the total cost will be non-refundable. _____

WE WILL RETAIN AN ADITTIONAL $1,000 RESCHEDULING FEE IF THE ABOVE REQUIREMENTS ARE NOT MET OR WE DETERMINE IT NECESSARY TO RESCHEDULE. _____

PATIENT SIGNATURE:_____DATE:_____

WITNESS SIGNCATURE:_____DATE:_____

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PLASTIC SURGERY

Conflict of Interest

During the course of your visits here at J.SWEAT Plastic Surgery, my staff or I may discuss, refer, prescribe or otherwise recommend products or service distributed, provided or endorsed by various corporations. I would like to inform you that I, Jeffrey Sweat, MD, have an ownership interest in Stathspey Crown Holding LLC, the parent company of ALPHAEON as well as ALPHEAON directly. I also have financial interest in Sientra, which manufactures breast implants. I have chosen to invest in these companies because I firmly believe that their products represent the best available products currently sold on the market. Additionally, I have a financial interest in the surgical facility at J.SWEAT Plastic Surgery, which is a routine for surgeons in private practice.

I am providing this information to you in order to help you make an informed decision about your health care. As always, you have the right to obtain health care services and products from J.SWEAT Plastic Surgery as well as any other heath care provider you choose. I completely respect your decision and will not treat you any differently if you choose to use or purchase a product or service other than those that I recommend. Upon, request I can provide information about alternative products or services.

By signing this notice, you are evidencing your informed decision to purchase ALPHAEON or Sientra product or service at your sole expense.

Acknowledged and accepted:

_____
(PATIENT NAME)