bodySCULPT™

SPERO J. THEODOROU, M.D.
CHRISTOPHER T. CHIA, M.D.

PF-1000 **Notice of Privacy Practices**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY NOT BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY

Uses and Disclosures
Treatment Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automatic insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Heath care operations. Your health information may be used as necessary to support the day-to-day activities and management of **bodySCULPT™** For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other user and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Use of Information
Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition, We may also send you information describing other health-related products and services that we believe may interest you.

bodySCULPT™

SPERO J. THEODOROU, M.D.
CHRISTOPHER T. CHIA, M.D.

Fund raising. Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please check off the following box.
[ ] Please do not use my information for fund raising purposes.

Individual Rights
You have certain rights under the federal privacy standards. These include:
The right to request restrictions on the use and disclosure of your protected health information
The right to receive confidential communications concerning your medical condition or treatment
The right to inspect and copy your protected health information
The right to amend or submit corrections to your protected health information
The right to receive an accounting of how and to whom your protected health info. Has been disclosed
The right to receive a printed copy of this notice

Duties of bodySCULPT™
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Rights to Revise Privacy Practices
A permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised polices and practices will be applied to all protected information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting **bodySCULPT™**. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:
If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

PF=2000 Acknowledgement of Receipt of Notice of Privacy Practices
bodySCULPT™ reserves the rights to modify the privacy practices outlined in this notice.

I have received a copy of the Notice of Privacy Practices for **bodySCULPT™**

_____
Name of Patient (Print or type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative (Patient / Guardian)
(If patient is a minor or adult legally unable to give consent)

bodySCULPT™

SPERO J. THEODOROU, M.D.
CHRISTOPHER T. CHIA, M.D.

_____
Relationship of Patient Representative to Patient
(If applicable)

_____
(Printed Name of Patient / Guardian)

I hereby request, authorize and give my consent to **Dr. Spero J. Theodorou/Dr. Christopher T. Chia** and associates, to perform surgery and whatever operations, treatments or technical procedures which may be deemed necessary or advisable in the diagnosis or treatment of my case. I also give my permission to have medications administered deemed necessary or advisable.

This particular operation, which I, _____am about to undergo has been explained tome in detail and I understand in general what is to be done, that there are risks, and that **Dr. Spero J. Theodorou/Dr. Christopher T. Chia** has not made any guarantee whatsoever.

Patient name: _____

_____ _____ _____
Patient Signature Date Witness Signature

_____ _____
Physician Signature Date

_____ _____
Signature of Parent/Guardian Date
(If patient is a minor or not legally
competent to consent)

_____ _____
Print Name of Parent/Guardian Relationship

bodySCULPT™

SPERO J. THEODOROU, M.D.
CHRISTOPHER T. CHIA, M.D.

Patient Name: _____ Date: _____

I have discussed with my physician, **Dr. Theodorou/ Dr. Chia**, the nature and purpose of a medical procedure, which is to be performed on: _____
Name of patient

This procedure that has been discussed is:
_____
_____

The doctor has fully explained to me the nature and purpose of this operation and has described that part of my body, which will undergo this operation.

I have received pre and post operative (before and after) instructions in both written and verbal forms.

I was given a chance to ask questions which had all been answered to my satisfaction and understanding.

My physician has fully explained the risks involved as well as the possible complications from the procedure.

I am aware that no guarantee or assurance as to the results of the operation together with any preoperative or postoperative treatment upon myself.

I authorize the operating surgeon to perform any procedures which may deem necessary to improve the condition for which I am being treated as well as for the operating surgeon as well as the use of such anesthetics deemed advisable.

I authorize my doctor, and/or assistants to take medical photographs to aid the preoperative analysis of my condition as well as for educational purposes.

I also consent to observers in the operating room as determined by the operating surgeon.

I authorize my doctor to disclose complete information concerning his medical findings and treatment for myself from the initial consultation to the date of the conclusion of my treatment to those individuals who, in my doctor's determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

_____ _____
Patient Witness

_____ _____
Guardian if patient is a minor or adult unable to sign consent — Relationship

_____ _____
Signature of Parent/Guardian (If patient is a minor or not legally competent to consent) — Date

_____ _____
Print Name of Parent/Guardian — Relationship

bodySCULPT™

SPERO J. THEODOROU, M.D.
CHRISTOPHER T. CHIA, M.D.

PATIENT: _____

DATE: _____

I understand that I will require an adult escort to accompany me home Following the operation as a matter of patient safety because I will have received medication during the procedure.

_____ _____
Signature Witness

_____ _____
Signature of Parent/Guardian Date
(If patient is a minor or not legally competent to consent)

_____ _____
Print Name of Parent/Guardian Relationship

bodySCULPT™

SPERO J. THEODOROU, M.D.
CHRISTOPHER T. CHIA, M.D.

Liposuction Surgery Operative Consent Form

PATIENT: _____

PROCEDURE: SmartLipo and suction assisted lipectomy of:

_____

I have had the opportunity to ask questions about the procedure, its limitations and possible complications. By placing my initials next to the following items, I express that I clearly understand and accept the following myself or through my legal guardian.

_____ 1. The goal of liposuction surgery, as in any other cosmetic procedure, is improvement of appearance. It does not guarantee the reduction of any measurements, including the neck, waist and all other areas.

_____ 2. The final results will not be apparent for 3-6 months post-operatively. There is no guarantee that the expected or anticipated results will be achieved.

_____ 3. In order to achieve the best possible results a "touch-up" procedure may occasionally be required.

_____ 4. Areas of "cottage cheese" texture (cellulite) will have little change after liposuction surgery.

_____ 5. Liposuction surgery is a body contouring procedure and is not performed for purposes of weight reduction.

_____ 6. Strict adherence to the post-operative regimen is necessary in order to achieve the best possible results.

bodySCULPT™

SPERO J. THEODOROU, M.D.
CHRISTOPHER T. CHIA, M.D.

Although complications following liposuction are very infrequent, by placing my initials next to the following, I understand that they may occur.

_____ 7. Bleeding is rare, and in rare instances could require hospitalization and blood transfusions. It is possible that blood clots may form under the skin and require subsequent surgical drainage. A collection of fluid (seroma) may develop which may require drainage.

_____8. Skin irregularities, lumpiness, hardness, and dimpling may appear post-operatively. Most of these problems disappear with time, but localized skin firmness, lumpiness and or irregularities may be permanent in rare instances. In dark-skinned patients, hyper-pigmented scars (dark to black scars) can occur and be permanent. Other objectionable scarring such as keloidsare possible. Other complications such as hematoma (collections of blood under the skin) can occur. If loose skin is present in the treated areas, it may or may not shrink to conform to the new contour.

_____ 9. Infection is rare, but should it occur, treatment with antibiotics and/or surgical drainage may be required.

_____10. Numbness or increased sensitivity of the skin over the treated areas may persist for months. It is possible that the localized areas of numbness or increased sensitivity could be permanent.

_____11. Objectionable scarring is rare because of the small size of the incisions used in liposuction surgery, but scar formation is possible.

_____12. Skin necrosis (skin loss) may occur as a result of liposuction in rare circumstances.

_____13. Allergic or toxic responses to anesthetic are extremely rare, but possible. In addition to these possible complications, I am aware of the general risks inherent in all surgical procedures and anesthetic administration.

_____14. I understand there may be a $500 touch up fee in rare circumstances associated with this procedure.

Patient Signature: _____

Witness: _____

bodySCULPT™

SPERO J. THEODOROU, M.D.
CHRISTOPHER T. CHIA, M.D.

My Signature certifies that I have discussed the above materials with the physician, I understand the goals, limitations and possible complications of liposuction surgery, and I wish to proceed with the operation.

_____	_____
Signature of Parent/Guardian (If patient is a minor or not legally competent to consent)	Date
_____	_____
Print Name of Parent/Guardian	Relationship