



SOUTHERN SURGICAL ARTS

The Art of Beauty

Dear Patient,

By now, you should have filled out your health information on our secure online patient portal (Step One on our Web site) and you should have read the welcome letter and patient information packet (Step Two on our Web site). The following are our new patient consents (Step Three on our Web site).

Again, our staff will be with you all the way: sharing our surgical skills and genuine concern about you and your experience. For a successful outcome, we will need to form a mutually responsible partnership. You will need to read and understand these consents. We will ask you to sign that you have read them and understand them when you come in for your appointment. If you need to see them again, we will be happy to provide them to you.

We appreciate your confidence, and we can assure you we will do our utmost to achieve the results you desire.

Sincerely,

Carey Nease, MD, Chad Deal, MD and Staff

Southern Surgical Arts

CONSENT #1: HEALTH HISTORY ACKNOWLEDGEMENT

The health history can be found on our online patient portal, which can be found on our Web site at <http://www.southernurgicalarts.com/index.cfm/PageID/8535>. This was Step One and should have already been completed.

I have completed the health history forms to the best of my knowledge. I have disclosed all the information related to my past and current medical history, including any medical diseases, past surgeries and current medications and allergies, and all other relevant information as requested. I understand the importance of disclosing this information and how it may affect the outcome of any service, treatment or surgical procedure performed by the physicians and staff at Southern Surgical Arts.

CONSENT #2: PATIENT RIGHTS AND RESPONSIBILITIES

In order for us to deliver consistent, professional, high quality service to you we have guidelines, which help us to achieve your expectations as well as responsibilities on your part as the patient. This is to inform you of our promise to you as your healthcare provider and your responsibilities to us. Please feel free to ask any questions or voice any opinions you may have concerning your healthcare. It is our goal to deliver exceptional care to you, our valued client.

PATIENT RIGHTS

- You have the right to prompt and adequate response to reasonable request and needs for treatment or services, within our capacity.
- You have the right to choose a healthcare provider who can give you high quality health care when you need it or to refuse examination or care by a specific healthcare professional. You have the right to refuse to participate in experimental research.
- You have the right to accurate and easily understood information about your health plan, healthcare professionals, and health care facilities. If you speak another language, have a physical or mental disability, or just don't understand something, help will be provided so you can make informed health care decisions.
- You have the right to information regarding services available at Southern Surgical Arts and the cost of these services.
- You have the right to know your treatment options and to take part in decisions about your care. Parents, guardians, family members, or others that you select can represent you if you cannot make your own decisions.
- You have a right to considerate, respectful care from your doctors, health plan representatives, and other health care providers that does not discriminate against you.
- You have the right to talk privately with health care providers and to have your health care information protected. You also have the right to a copy your own medical record. You have the right to ask that your doctor document in your records any corrections to inaccurate, irrelevant, or incomplete information.
- You have a right to a fair, fast, and objective review of any complaint you have against your health plan, doctors, hospitals or other health care personnel. This includes complaints about waiting times, operating hours, the actions of health care personnel, and the adequacy of the health care facility.
- You have the right upon request to receive a copy of any itemized bill or statement of your charges.
- You have the right to after hours contact numbers. You may contact a nurse after hours at 770-773-0880 or 770-548-3318. If a medical emergency arises always dial 911.
- You have a right to our payment policy for all services rendered.
- You have a right to all credentials for the facility and for healthcare professionals.

PATIENT RESPONSIBILITY

- You are responsible for providing complete and accurate information to the best of your ability about your health, any medications, including over the counter products and dietary supplements, present complaints, past illnesses, hospitalizations, advanced directives, power of attorney, or other directive that could affect your care, any allergies or sensitivities, and other matters relevant to health or care.

- You are responsible for keeping all appointments or contacting the office 24 hours prior to your appointment to cancel.
- You are responsible to inform Southern Surgical Arts promptly if you do not understand any matter relating to your care and treatment or instructions with which you cannot comply.
- You are responsible to follow the treatment plan prescribed by your provider.
- You are responsible to be considerate to other patients and to see that any person with you is considerate, particularly with reference to noise.
- You are responsible for providing a responsible driver to transport you home and remain with you for 24 hours if required by your physician.
- You are responsible to observe the smoke-free policy at our office.
- You must accept personal financial responsibility for any charges for services rendered at Southern Surgical Arts and for any charges not covered by insurance if insurance is filed.
- You are responsible to provide necessary information regarding coverage of your charges.
- You must be respectful to all the health care providers and staff.
- You are responsible for your actions if you refuse treatment or do not follow your provider's instructions.
- You are responsible for all products purchased at Southern Surgical Arts and understand that these may be prescription products, which are by state law nonrefundable.

CONSENT #3: PRIVACY NOTICE

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 Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Southern Surgical Arts may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless Southern Surgical Arts has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

A. TREATMENT. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes coordination or management of you health care with a third party for treatment purposes. For example, we may disclose your protected health information to a laboratory, pharmacy or treating physicians.

B. PAYMENT. Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurance company to get approval for the procedure that we have scheduled (i.e. pre-authorization or prior approval). We may also disclose protected health information to your health insurance company to determine your eligibility for benefits or whether a particular service is covered under your plan or to demonstrate medical necessity of the services or as required by your insurance company, for utilization review. We may also disclose protected health information to another provider involved in your case for the other provider's payment activities. This may include disclosure of demographic information to anesthesia care providers.

C. OPERATIONS. We may use or disclose your protected health information as necessary for our own health care operation to facilitate the function of the ASC and to provide quality care to all patients. Health care operations include such

activities as: quality assessment and improvement activities, employee review activities, post operative patient assessment, training programs, including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensure, or credentialing activities, review and auditing, including compliance review, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities.

D. OTHER USES AND DISCLOSURES. As a part of your treatment, payment and health care operations, we may also use or disclose your protected health information for the following purposes: to remind you of your surgery date, provide pre-operative instructions and discuss financial arrangements.

USES AND DISCLOSURES BEYOND TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS PERMITTED WITHOUT AUTHORIZATION OR OPPORTUNITY TO OBJECT

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. WHEN LEGALLY REQUIRED. We will disclose your protected health information when we are required to do so by any federal, state, or local law.

B. WHEN THERE ARE RISKS TO PUBLIC HEALTH. We may disclose your protected health information for the following public activities and purposes:

- * To prevent, control, or report disease, injury or disability as permitted by law.
- * To report vital events such as birth or death as permitted by or required by law.
- * To conduct public health surveillance, investigations and interventions as permitted or required by law.
- * To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance.
- * To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- * To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

C. TO REPORT SUSPECTED ABUSE, NEGLECT, OR DOMESTIC VIOLENCE. We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence when specifically required or authorized by law or when the patient agrees to the disclosure.

D. TO CONDUCT HEALTH OVERSIGHT ACTIVITIES. We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information under this authority if you are the subject of an investigation and your health information is not directly related to your receipt of healthcare or public benefits.

E. IN CONNECTION WITH JUDICIAL AND ADMINISTRATIVE PROCEEDINGS. We may disclose your health information in the course of any judicial or administrative proceedings in response to an order of a court of administrative tribunal as expressly authorized by such order. In certain circumstances, we disclose your health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. FOR LAW ENFORCEMENT PURPOSES. We may disclose your health information to a law enforcement official for law enforcement purposes as follows:

- * As required by law for reporting of certain types of wounds or other physical injuries.
- * Pursuant to court order, court-ordered warrant, subpoena, summons or similar process.
- * For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- * Under certain limited circumstances, when you are the victim of a crime.

- * To a law enforcement official if the Center has a suspicion that your health was the result of a crime.
- * In an emergency to report a crime.

G. TO CORONER, FUNERAL DIRECTORS, AND ORGAN DONATION. We may disclose health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties.

H. FOR RESEARCH PURPOSES. We may use or disclose your health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

I. IN THE EVENT OF A SERIOUS THREAT TO HEALTH OR SAFETY. We may, consistent with applicable law and ethical standards of conduct, use or disclose your health information if we believe, in good faith that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health and safety or to the health and safety of the public.

J. FOR SPECIFIED GOVERNMENT FUNCTIONS. In certain circumstances, federal regulations authorize the Center to use or disclose your health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

K. FOR WORKER'S COMPENSATION. The Center may release your health information to comply with worker's compensation laws or similar programs.

Uses and Disclosure Permitted without Authorization but with Opportunity to Object.

We may disclose your health information to your family member or a close family friend if it is directly relevant to the person's involvement in your surgery or payment related to your surgery. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your health information.

Uses and Disclosures which you Authorize.

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have action in reliance upon the authorization.

Your Rights.

You have the following rights regarding your health information:

A. THE RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION. You may inspect and obtain a copy of your health information that is contained in a designated record set for as long as we maintain the health information. A "designated record set" contains medical and billing records and any other records that your surgeon and the Center use for making decisions about you. Under the federal law, however, you may not inspect or copy the following records:

- * Psychotherapy notes. Information compiled in reasonable anticipation or, or for use in, a civil, criminal, or administrative action or proceeding; and health information that is subject to a law that prohibits access to health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed. We may deny your request to inspect or copy your health information, if in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced with the information. You have the right to request a review of this

decision. To inspect and copy your medical information, you submit a written request to the Privacy Officer whose contact information is listed on the last page of this Privacy Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request. These costs will be made known to you at the time of your request.

B. THE RIGHT TO REQUEST A RESTRICTION ON USES AND DISCLOSURES OF YOUR HEALTH INFORMATION. You may ask us not to use or disclose certain parts of your health information for the purposes of treatment, payment or health care operations. You also request that we do not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply. The Center is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the Center does agree to the requested restriction, we not use or disclose your health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstance, we may terminate our agreement to a restriction.

C. THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS FROM US BY ATLEARNATIVE MEANS OR AT AN ALTERNATIVE LOCATION. You may have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request.

D. THE RIGHT TO REQUEST AMENDENTS TO YOUR HEALTH INFORMATION. You may request an amendment of health information about you in a designated record set for you as long as we maintain this information. In certain cases, we may deny your request. If we deny your request, 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. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.

E. THE RIGHT TO RECEIVE AN ACCOUNTING. You may have the right to request an accounting of certain disclosures of your health information made by this Center. This right applies to disclosure for purposes other than treatment, payment or health care operations as described in the Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing and authorization form disclosures for a Center directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. THE RIGHT TO OBTAIN A COPY OF THIS NOTICE. Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of this notice.

Our Duties.

Southern Surgical Arts is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future health information that we maintain. If the **Southern Surgical Arts** changes its Notice, we will provide a copy of the revised Notice by sending a copy of the revised Notice via regular mail or through in-person contact.

Complaints.

You have the right to complaints to Southern Surgical Arts and to the secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the Center by contacting the Privacy Officer verbally or in writing,

using the information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person.

This Center's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by this Center, you may submit a complaint to our Privacy Officer at:

Southern Surgical Arts
120 Cornerstone Way, Suite 3
Calhoun, GA 30701
ATTN: Privacy Officer

The Privacy Officer can be contacted by telephone at **706-629-8622**

Effective Date.

This Notice is effective April 14, 2003

CONSENT #4: NON-PARTICIPATING ACKNOWLEDGEMENT

Dr. Nease and Dr. Deal do not submit insurance claims for any services rendered nor do they help facilitate the insurance claim process (including providing insurance codes). If I choose to apply for insurance reimbursement that I will be responsible for submitting claims to my insurance company. I will be provided all required medical records from Southern Surgical Arts to submit these claims.

CONSENT #5: MEDICARE/MEDICAID AGREEMENT

Dr. Nease and Dr. Deal do not participate with Medicare/Medicaid and will not submit claims to Medicare/Medicaid for services rendered. I will not in any way submit a claim to Medicare/Medicaid for any services provided by Dr. Nease or Dr. Deal.

CONSENT #6: FINANCIAL POLICY

Cancellation & Financial Policy (for non-surgical procedures and appointments)

We understand that a situation may arise that could force you to postpone your consultation and other non-surgical appointments. Please understand that such changes affect not only your surgeon, but other patients as well. The physician's time, as well as that of other staff, is a precious commodity, and we request your courtesy and concern.

To schedule an appointment for a consultation with Dr. Nease or Dr. Deal, we require that you provide a credit card. We do not charge you for the consultation unless you do not provide a 24-hour courtesy notice. In that case, **we charge your credit card \$50.** We understand emergencies.

If you have any questions or need assistance with financial matters, please ask Tracie Lance, our financial director, to help you.

Financial Policy (for surgical patients)

Once you decide to have surgery with Dr. Nease or Dr. Deal, our financial policy is as follows. It is to assure that you have the best surgical experience possible and are fully informed throughout our relationship.

- 10% of your surgical fees are due when you select a surgery date. **This is a non-refundable deposit.** The deposit **cannot** be applied or used for any future cosmetic procedures, products or services in our medical spa. We **cannot** schedule your surgical procedure without receiving the 10% deposit.
- Your final balance is due two (2) weeks prior to your surgery date and is non-refundable.** There will be no exceptions to this policy. If payment is not received two (2) weeks prior to surgery, your surgery may be postponed or cancelled.
- If your surgery is scheduled within two weeks from the date of consultation, we cannot accept a personal check.
- You may reschedule 48 hours prior to the surgery date in the event of an emergency. Cancellations made within 48 hours of surgery will not be refunded. The procedure may be rescheduled at the discretion of Dr. Nease or Dr. Deal and a rescheduling fee, minimum \$500, may apply.
- Testing for nicotine is routinely performed on patients the day of surgery. Should you test positive for nicotine products, we reserve the right to cancel your procedure for that day. Refunds will not be given in this instance; however, your procedure may be rescheduled for a later date at Dr. Nease or Deal's discretion. Should you choose or be allowed to reschedule your procedure, a minimum fee of \$1000 will be required.
- We accept all major credit cards, cash or check. We also offer patient financing through Care Credit, GlamourCredit, and Chase Health Advance. We are happy to provide you with information regarding these programs, and we have a full-time financial coordinator on staff to assist you with your financing choices.
- Prescription medications and lab work are additional and NOT part of your fees from Southern Surgical Arts.

CONSENT #7: SMOKING CONSENT

Smoking, Second-Hand Smoke Exposure, Nicotine Products (Patch, Gum, Nasal Spray)-

Patients, who are currently smoking, use tobacco products, or nicotine products (patch, gum, or nasal spray) are at a greater risk for significant surgical complications of skin necrosis, delayed healing, and additional scarring. Individuals exposed to second-hand smoke are also at potential risk for similar complications attributable to nicotine exposure. Additionally, smoking may have a significant negative effect on anesthesia and recovery from anesthesia, with coughing and possibly increased bleeding. Some complications that are at a higher risk due to smoking are: bleeding, infection, blood clots, pulmonary embolus, poor healing, increased bruising, major wound breakdown, failure of flap surgery, wound and chest infections, pneumonia, thrombosis, and heart and lung complications. Individuals who are not exposed to tobacco smoke or nicotine-containing products have a significantly lower risk of this type of complication.

CONSENT #8: AGREEMENT AS TO RESOLUTION OF CONCERNS

“Physician” shall be understood to mean **Carey Nease, MD** or **Chad Deal, MD**.

I understand that I am entering into a contractual relationship with one of the above named Physicians for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the Physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be diplomats in good standing of the **American Board of Cosmetic Surgery (ABCS)**. I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the ABCS and that the expert(s) will be obligated to fully consent to formal review of conduct by such society and its members.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions. In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and Physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/guardian and Physician *acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.*

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

CONSENT #9: MEDICATIONS, VITAMINS AND SUPPLEMENTS TO AVOID

1. Your safety in surgery requires that you disclose all medications, vitamins and supplements that you regularly take. In the days prior to surgery, you will 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 any and all medications you take during the 14 days prior to surgery.**

If you have taken a medication that may put you at risk for a complication such as excess bleeding, it may require that your surgery be rescheduled or postponed. This is for your safety. Before you stop taking any prescription drugs, you must receive clearance from the prescribing physician. Please notify our office immediately if you do not receive clearance to stop taking your prescribed medications. The following drugs could cause life-threatening problems with surgery. If you are on any of the following medications, you must discuss this with the doctor. Patients who take these drugs may require laboratory tests and a consultation to determine when they may safely undergo a surgical procedure. These include but are not limited to:

Coumadin	Elmiron – IC	Accutane	Steroids Methotrexate
Plavix	Persantine	Fragmin	
Non-Prescribed or Illicit Drugs		Low Molecular Weight Heparin	

Aspirin, aspirin-containing medications and anti-inflammatory agents must not be taken in the **2 weeks** prior to your scheduled surgery date. Always read the active ingredients on any over-the-counter or prescription medications. For your reference, we have attached is a list of common drugs containing aspirin. Aspirin and aspirin containing medications include, but are not limited to, the following:

Alka Seltzer	ASA + Codeine	Carisprodal Compound
Equagesic	Momentum	Propox Demi
Alka Seltzer Plus	Ascriptin	Cope
Excedrin	Norgesic	Robixisal
Anacin	Asperbuf	Darvon Compound
Fiorinal	Norgesic Forte	Sine Off
APAC Tablets	Aspergum	Darvon Compound 65
Fiorinal #3	Orphengesic	Synalgos
Sodium Salicylate	APC Tablets	Axotoal
Doan's Pills	Lortab ASA	Orphengesic Forte
SOMA	Arthritis Pain Reliever	BAC

Ecotrin	Magnaprin	PAC
Synalgos DC	Arthropan	Bayer Aspirin
Emprin Compound	Measurin	Pamprin
Trigesic	Aspirin Tablets USP	Bufferin
Emprin Compound #3	Medipren	Percodan
Vanquish	ASA	Butalbital Compound
Encarprin	Midol	Percodan Demi

There are several medications that fall under a separate category that must also be discontinued 2 weeks prior to your scheduled surgery date. A list of these medications is as follows:

Anti-Inflammatory medications include, but are not limited to, the following:

Advil	Cataflam	Ibuprofen	Motrin
Orudis	Toradol	Aleve	Clinoril
Ifen	Nalfon	Ovuvail	Voltarten
Anaprox	Daypro	Indocin	Naprosyn
Phenylbutazone	Ansaid	Dolobid	Indomethocin
Naproxen	Ruten	Butazoladin	Feldene
Meclomen	Nuprin	Tolectin	

Additional medications to avoid include, but are not limited to the following:

Chloratrimeton	Pamelor	Ru – Tuss	Endep
Elavil	Lioresal	Zomax	Oraflex
St. John's Wort	Vibramycin	Etiafon	
Phentermine	Imitrex	Tagamet	
Vitamin E	Flexeril	Mysteclin F	
Phendimetrazine	Parnate	Surmontil	
Flagyl	Nicobid	Triavil	
Tetracycline	Tenuate	Dospan	

CONSENT #10: CONSENT FOR PHOTOGRAPHY

As a patient of Southern Surgical Arts, I agree to be photographed before, during and/or after the course of treatment. I give Southern Surgical Arts the ongoing and unrestricted right to use the photographs for general information, education, public relations and marketing purposes.

I understand that I relinquish all rights, title and interest in these photographs, or any right to profit or gain directly or indirectly realized through the use of the photographs. I can revoke this consent only in writing and it will not be revoked by implication.

I have read and understand the policy for Consent for Photography. I have been given opportunity to ask questions and voice any concerns about the policies outlined and all answers have been explained to me in detail. My signature attests my understanding and satisfaction with the answers I have been given, and I desire to proceed with the relationship as outlined in the Agreement.