



Board Certified Plastic Surgeon

PATIENT INFORMATION					
LAST NAME		FIRST NAME			M.I.
SSN	DATE OF BIRTH	SEX	MRN		
STREET ADDRESS					
STREET ADDRESS CONTD.					
CITY		STATE TX	ZIP CODE		
HOME PHONE		CELL PHONE		EMPLOYER NAME	

## A HIPAA

### Notice of Privacy Practices

STEPHANIE K TEOTIA, MD PA  
 PLASTIC & RECONSTRUCTIVE SURGERY  
 4231 CEDAR SPRINGS RD, DALLAS, TX 75219

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 Notice of Privacy Practices (the "Notice") tells you about the ways we may use and disclose your protected health information ("medical information") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to Stephanie K Teotia, MD PA including its providers and employees (the "Practice").

#### I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you; Notify affected individuals following a breach of unsecured medical information under federal law; and Follow the terms of the version of this Notice that is currently in effect.

#### II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

C. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with

do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Psychotherapy Notes, Marketing and Sale of Medical Information. Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

C. Right to Revoke Authorization. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

#### IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend. If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

**S.Legal Matters.** If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

**T.Law Enforcement, National Security and Intelligence Activities.** In certain circumstances, we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**U.Coroners, Medical Examiners and Funeral Home Directors.** We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

**V.Inmates.** If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

**W.Marketing of Related Health Services.** We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

**X.Fundraising.** We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

**Y. Electronic Disclosures of Medical Information.** Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

### III.OTHER USES OF MEDICAL INFORMATION

**A. Authorizations.** There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to

opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

K.As Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

L.To Avert an Imminent Threat of Injury to Health or Safety. We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

M.Organ and Tissue Donation. If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

N.Research. We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is "de-identified."

O.Military and Veterans. If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

P.Workers' Compensation. We may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

Q.Public Health Risks. We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).

To report births and deaths.

To report suspected child abuse or neglect.

To report reactions to medications or problems with medical devices and supplies.

To notify people of recalls of products they may be using.

To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

To provide information about certain medical devices.

To assist in public health investigations, surveillance, or interventions.

R.Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. For Payment. We may use and disclose medical information about you so that we may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law. We may use and disclose your medical information to your credit card company if there are disputes about services and payments.

C. For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. Quality Assurance. We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. Utilization Review. We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. Credentialing and Peer Review. We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

G. Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

H. Appointment Reminders and Health Related Benefits and Services. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you. Forms of communication include letters, phone calls, email and texting.

I. Business Associates. There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

J. Individuals Involved in Your Care or Payment for Your Care. We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an

which we will not be able comply. Your request must specify how and where you wish to be contacted.

F.Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G.Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

#### V.CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

#### VI.COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Stephanie K Teotia, MD PA  
Attn: HIPPA Officer  
4231 Cedar Springs Rd  
Dallas, TX 75219  
214-823-9652

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

#### VII.ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this Notice of Privacy Practices prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein. All restrictions regarding the use and/or disclosure of your health records should be sent the to practice in writing.

*I consent to the above.*

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Patient / Agent / Guardian Signature

## A Photographs

### Authorization For Use And Release Of Medical Photographs

This is a consent document that has been prepared to help inform you concerning granting permission to take photographs and to use these images for a purpose as defined within this consent document. Upon review, please sign the consent. Medical photographs may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images. This practice has a policy requiring all patients seeking elective surgery to undergo preoperative photography at a minimum as part of prudent record keeping and to permit appropriate surgical planning. Elective cosmetic surgery may be denied to patients who refuse medically necessary preoperative photography.

#### CONSENT TO TAKE PHOTOGRAPHS

I hereby authorize the surgeon and the surgeon's associates or staff to take pre-operative, intra-operative, and post-operative photographs. I additionally consent to photographs during my consultation/office visit.

Please Initial ONE of the following:

#### ALL MEDIA

\_\_\_\_\_ Photographs taken of me or parts of my body as well as details regarding medical services I have received at Dr. Stephanie Teotia's practice may be used in any print or broadcast media, including but not necessarily limited to newspaper, pamphlets, educational films, our internet website, social media and television, in order to inform the public about plastic surgery methods. Further, I release and discharge Dr. Stephanie Teotia, the facility used, the American Society of Plastic Surgery, and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publications and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claims for payment in connection with any such use or publications. I give my consent as a voluntary contribution in the internet or public education and my consent is subject only to the condition that I am not identified by name at any time during any use of publication of these materials by any party.

#### INTERNET ONLY

\_\_\_\_\_ Photographs taken of me or parts of my body as well as details regarding medical services I have received at Dr. Stephanie Teotia's practice may be used on our internet website as well as our social media accounts, including but not necessarily limited to Facebook, Instagram, and Twitter, in order to inform the public about plastic surgery methods. Further, I release and discharge Dr. Stephanie Teotia, the facility used, the American Society of Plastic Surgery, and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publications and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claims for payment in connection with any such use or publications. I give my consent as a voluntary contribution in the internet or public education and

my consent is subject only to the condition that I am not identified by name at any time during any use of publication of these materials by any party.

**IN-CLINIC USE ONLY**

\_\_\_\_\_ Photographs taken of me or parts of my body as well as details regarding medical services I have received at Dr. Stephanie Teotia's practice may be used in the practice photograph album in order to inform other patients about plastic surgery methods. Further, I release and discharge Dr. Stephanie Teotia, the facility used, the American Society of Plastic Surgery, and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publications and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claims for payment in connection with any such use. I give my consent and my consent is subject only to the condition that I am not identified by name at any time during any use of these materials by any party.

**MEDICAL CARE ONLY**

\_\_\_\_\_ Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Dr. Stephanie Teotia, Plastic and Reconstructive Surgery. These photographs will be used for pre-operative planning and post-operative evaluation. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Dr. Stephanie Teotia's practice.

*By my signature, I hereby acknowledge receipt and understanding of this form. I consent to the above.*

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Patient / Agent / Guardian Signature

**General Consent and Policies**

**INSURANCE AUTHORIZATION (IF PATIENT HAS INSURANCE)**

I hereby consent to allow Dr. Stephanie Teotia and her staff to perform all necessary procedures, drug administration and tests on myself or my family member. I understand and agree that I am financially responsible for the account balance regardless of whether or not paid by insurance. Insurance plan coverage frequently changes. It is the legal responsibility of the patient to determine whether or not Dr Teotia is in-network or out-of-network with the insurance provider. It remains the sole responsibility of the patient to be aware of his or her own plan coverage and benefits. Our office will verify your insurance eligibility and benefits prior to a procedure based on the information given. If the insurance information given to our office is inaccurate, then you will be responsible for the payment. Our office will calculate if you have any co-insurance (deductible and out-of-pocket amounts) due prior to the procedure. Full payment will be due at the time of your service. You may be required to place a credit card on file if the amount that you owe is unknown. The amounts are strictly an estimate. You may also owe money to anesthesia and the surgery center. If you are owed a refund from Dr Teotia following the procedure, a check will be issued to you approximately 90 days post procedure. This allows enough time to ensure that the insurance company has

finishing reviewing all bills related to the surgery. I hereby release Dr Teotia to submit all necessary information in order to secure payment of benefit. I authorize the use of my signature on all insurance submissions.

#### MEDICARE AUTHORIZATION (IF PATIENT HAS MEDICARE)

I request that authorized Medicare payments be made on my behalf to Stephanie K Teotia, M.D. PA for services furnished to me. I authorize any holder of information about me to be released to the Division of Medicare and Medicaid Services and its agents any information needed to determine those benefits payable for related services. I understand that my signature requests that payment be made and authorized release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

#### COSMETIC SURGERY

Deposit: A \$500 deposit is required to secure a cosmetic surgery date. We accept most credit cards. Personal checks or cash are acceptable for the deposit. A money order or cashiers check is required for amounts over \$2000. You may also use patient financing options. The final payment for surgery is due two weeks prior to your surgery date. If your payment is NOT received at least two weeks prior to your surgery, we will need to reschedule your surgery.

#### CANCELLATION AND RESCHEDULING POLICY FOR COSMETIC SURGERY

Full Payment for all surgical procedures must be made two weeks prior to the scheduled surgery date. When you schedule and complete the full payment for your procedure, Dr. Teotia and the staff make necessary arrangements in anticipation of your surgery on the appointed date. Once surgery is scheduled, the staff prepares all the required resources to make your surgery comfortable and successful. This entails coordination between physicians, the surgery center or hospital, and the operating room staff, as well as the anesthesiologist, if applicable. In addition, special medical instrumentation is prepared and sterilized for each individual procedure, and in many cases, implants or other products need to be ordered. Finally, scheduling surgery blocks the surgeons and staffs time from being available to other patients. Accordingly, all patients must understand the importance of respecting the offices Cancellation and Rescheduling Policy.

Any pharmaceutical product that must be mixed/activated prior to the procedure (or injection) must also be paid in full prior to proceeding. Once the product is mixed/activated, the cost of the product will not be refunded to the patient if cancellation occurs. The same policy exists for any product that is ordered and cannot be returned.

Surgery Cancellation/ Reschedule 15 or more days prior to procedure date:

You will be charged a non-refundable fee of 10% of the surgical fee or \$500.00, whichever is greater, which will be deducted from your refunded amount.

Surgery Cancellation/ Reschedule 8-14 days prior to procedure date:

A 25% non-refundable surgical fee will be deducted from your refunded amount.

Surgery Cancellation/ Reschedule 1-7 days prior to procedure date:

A 50% non-refundable fee surgical fee will be deducted from your refunded amount.

Surgery Cancellation/ Reschedule 1 day or less from your procedure date will result in 100% loss of all fees.

#### PRIOR TO SURGERY (COSMETIC OR INSURANCE)

**Stop Smoking:** Smoking reduces circulation to the skin and impedes healing. Dr Teotia rarely operates on active smokers. If you feel this detail was not discussed during your consultation, please contact the office.

**Labs:** All patients must have blood work (and possibly an EKG, urine analysis and chest X-ray) performed one month prior to their procedure.

**Mammogram:** Female patients over 40 years of age require a baseline mammogram (within one year) prior to any breast procedure.

**Medical Clearance:** If you have been told that you require medical clearance by your internist or primary care provider prior to surgery, please schedule this appointment. Your results should be faxed or mailed to Dr Teotia's office.

**Filling Your Prescriptions:** You will be given prescriptions for your post operative medications prior to your surgical procedure. Please have your prescriptions filled and bring the medication with you on the day of surgery.

**Stop taking blood thinners, estrogen or herbal supplements:** Please review the list of medications that you should stop approximately 10 days prior to your procedure.

**Post Surgery Arrangements:** You must arrange for a responsible adult to drive you to and from surgery. An adult must remain with you for the first 24-72 hours (depending on the surgical procedure). Please make all arrangements for care and transportation in advance. Dr. Teotia's office can assist setting up post operative care with a nursing company if needed.

#### THE DAY BEFORE SURGERY

**Eating & Drinking:** Do NOT eat or drink anything after midnight the night before your surgery (including water). If you are scheduled for surgery after 2pm, we may allow water or black coffee before 6 am. Please ask Dr. Teotia's staff if you are permitted to do this.

**Cleansing:** The night before and the morning of surgery, shower and wash the surgical areas with Hibiclens.

#### THE DAY OF SURGERY

**Eating and Drinking:** Do NOT eat or drink anything the morning of surgery! You may brush your teeth but DO NOT swallow any water.

**Medications:** You may take blood pressure and reflux medications with a very small sip of water.

**Hygiene and Clothing:** Please shower and wash the surgical areas again with Hibiclens or antibacterial soap. Do NOT apply deodorant. Please remove ALL make-up and do NOT wear moisturizers, creams, or lotions. Wear comfortable, loose fitting, clothing that does not have to go over your head. If you wear contact lenses, please remove them prior to arriving for surgery. You may wear eye glasses. Remove hairpins, wigs, metal related to hair extensions and all jewelry (including any piercings).

**Pregnancy Test:** If you could be pregnant, a pregnancy test will be given on the day of your surgery.

#### THE OPERATING ROOM

Dr. Teotia and her staff recognize that the operating room is NOT a normal experience for most patients. We recognize the natural anxiety that most patients feel. A description of the surgery experience may be helpful. Your surgery will be performed at one of our accredited surgical facilities using the most modern equipment and techniques. The team will include a board-certified anesthesiologist, trained operating room technician and registered nurses. When you arrive at the facility, you will be escorted to the pre-operative room. You will be asked to change onto a gown and robe. Dr. Teotia and the anesthesiologist will meet with you. This is the time for final surgical planning. There will be time for questions. Once you enter the operating room, the staff will do everything they can to make you feel secure.

#### THE RECOVERY ROOM

When your surgery has been completed and your dressings are in place, you will be moved to the recovery room. You will be connected to monitoring equipment constantly. During this period, a fully trained recovery room nurse will take care of you. Most patients are fully awake within 30-60 minutes

after surgery. However, you may not remember a lot about your stay in the recovery room area.

#### POST-OPERATIVE CARE - FIRST 48 HOURS

**Excessive Bleeding or Pain:** If you have excessive bleeding or pain, call our office immediately.

**First 24 Hours:** If you are going home, a family member or friend must drive you home if you have been sedated for your procedure. Someone should stay overnight with you. Should you require overnight assistance, we can provide you with at-home nursing care information (an additional charge). All arrangements and payments are required 2 weeks before your surgery date.

**Dressings:** Keep your dressings as clean and dry as possible. Do NOT remove them unless you are instructed by Dr Teotia to do so.

**Activity:** Take it easy and pamper yourself. Try to avoid any straining or heavy lifting. You may go to the bathroom, sit and watch television, etc. but **NO MATTER HOW GOOD YOU FEEL, DO NOT CLEAN THE HOUSE, REARRANGE THE ATTIC, ETC.** We do not want you to bleed and cause any swelling and bruising that is unnecessary.

**Ice Packs:** Cold ice packs help reduce swelling, bruising, and pain. Use frozen peas in the package or crushed ice cubes placed in a zip-lock bag. Ice should be placed in a towel or cloth and NOT directly on the skin. This should help and NOT hurt. If the ice feels too uncomfortable, DO NOT use it as often. Twenty minutes on and twenty minutes off is the general rule of thumb.

**Diet:** If you have any post-operative nausea, carbonated sodas and dry crackers may settle your stomach. If you feel normal, start with liquids and bland foods. Once these are well tolerated, progress to a regular diet. No greasy foods for at least 48 hours after surgery, as this can cause nausea, diarrhea, vomiting, etc.

**Smoking:** Smoking reduces blood flow to your skin. We advise you to NOT smoke at all after the surgery as this WILL impede the healing process.

**Alcohol:** Alcohol could increase post-operative bleeding. Please DO NOT drink until you have stopped taking the prescription pain pills and antibiotics that were prescribed by Dr Teotia. The combination of pain pills and alcohol can be extremely dangerous.

**Driving:** Please do not drive for at least 2 days after general anesthesia, intravenous sedation or while taking prescription pain medication. Please have transportation arrangements for your post-operative appointments as well, for it is VERY important that you follow the schedule of appointments Dr. Teotia and her staff have established for you post-operatively.

#### GENERAL SURGICAL RISKS

We want you to fully understand the risks involved in surgery so that you can make an informed decision. Although complications are infrequent, ALL surgeries have some degree of risk. Dr. Teotia and her staff will use their expertise and knowledge to avoid complications. In general, the least serious problems occur more often and the more serious problems occur rarely. If a complication does arise, you, Dr. Teotia, and the staff will need to cooperate in order to resolve the problem expeditiously. Most complications involve an extension of the recovery period rather than any permanent effect on your final result.

#### NORMAL SYMPTOMS

**Swelling & Bruising:** Moderate swelling and bruising are normal after any surgery. Severe swelling and bruising may indicate bleeding or a possible infection.

**Discomfort & Pain:** Mild to moderate discomfort or pain is normal after surgery. If the pain becomes severe and is not relieved by pain medication, please contact our office immediately at 214.823.9652.

**Crusting Along the Incision Lines or Oozing:** This is not unusual. DO NOT pick or peel off any adhesives or tapes unless instructed to do so by Dr. Teotia or her staff.

**Numbness:** Small sensory nerves to the skin surface are occasionally divided when the incision is made or interrupted by undermining of the skin during surgery. The sensation in those areas gradually returns within 1-3 months (depending on the patient and the procedure) as the nerve endings heal

spontaneously. As these heal, mild shooting electrical sensations may be felt as the nerves rejuvenate.

Itching: Itching within the skin or muscle frequently occurs as the nerve endings heal. Ice, skin moisturizers, and massages are frequently helpful. These symptoms are common during the recovery period.

Redness of Scars: All new scars are typically red, dark pink, or purple. Scars on the face usually fade within 6 months. Scars on the breast or body may take a year or longer to fade completely. Scar treatments and products are available and recommended as you heal. We recommend you protect your scar by keeping it out of the sun (UV lights) and/or wear sunscreen until the red pigmentation is completely gone.

#### COMMON RISKS

Hematoma: Small collections of blood under the skin could occur and are usually allowed to absorb spontaneously. Larger hematoma may require aspiration, drainage, or even surgical removal to achieve the best results.

Inflammation & Infection: A post-operative antibiotic will be given for most procedures. However, this does NOT guarantee that no infection will occur. A superficial infection may simply require antibiotic ointment. Deeper infections are treated with additional antibiotics. Development of abscesses or deep pockets usually requires incision opening and drainage, and may need to be left open until the tissue has time to heal.

Thick, Wide, or Depressed Scars: Abnormal scars may occur even though we have used the most modern plastic surgery techniques. Injections of steroids into the scars, placement of silicone sheeting onto the scars, or further surgery to correct the scars is occasionally necessary. Some areas on the body scar more than others and some people scar more than others. Your own history of scarring should give you some indication of what you can expect. We offer a scar treatment product to facilitate the best scars possible.

#### REVISION POLICY

Plastic surgery is NOT an exact science and therefore perfect results have not been, and cannot be, guaranteed. Results of plastic surgery may take 6-12 months or longer to be final. Preoperative expectations may not be fully realized with surgical results. Dr Teotia exercises considerable judgment before, during, and after any surgical procedure in order to optimize results. Every effort is paid to achieving reasonable patient satisfaction and avoiding complications. In any surgeon's hands, complications may occur, in spite of efforts to avoid them. This may require a return to the operating room. However, even in the absence of complications, there is the possibility of patient cosmetic dissatisfaction with the outcome. In other cases, the patient may be satisfied overall, but desire some additional procedures or touch-ups to the results. In some cases, this may prompt the patient to seek additional surgery, including revision of the surgical site, which may require anesthesia and a return to the operating room. Patients will be responsible for the operating and anesthesia fees associated with the procedure, as well as the costs of implants and other surgical devices and products recommended by Dr. Teotia. The surgeon's fee will be waived if the revision is within six months of the initial surgery.

*I have read the above information and understand the policies and expectations.*

---

Witness Signature

---

Patient / Agent / Guardian Signature