1. PATIENT CONSENT TO MEDICAL CONSULTATION AND TREATMENT
I request and authorize Winslow Facial Plastic Surgery and their respective agents and employees ("WFPS") who may attend me during my treatment to perform routine tests and procedures and to provide certain services as prescribed for my health and well-being in accordance with applicable laws and regulations. I acknowledge that no representations, warranties, or guarantees as to results of cures have been made to me by WFPS, nor have I relied upon any such representations, warranties, or guarantees. I also acknowledge and agree that no refunds are available. All in-office credits expire 12 months from date of issue and all other in-house procedural payments expire 24 months from date of payment.

Patient Signature ___________________________________________ Date __________
Witness ___________________________________________ Date __________

2. OTHER CONSENTS AND ACKNOWLEDGEMENTS

HIPAA
By signing below, I acknowledge that I have received a copy of the WFPS Patient Admission Packet, which includes but is not limited to the HIPAA Notice of Privacy Practices ("Notice"). I understand that I may obtain a written copy of this Notice at any time upon request or via the website at http://www.IndyFace.com.

LATE OR CANCELLED APPOINTMENTS/REFUND POLICY
By signing below, I hereby acknowledge that if I am more than ten (10) minutes late for a scheduled appointment, I will be asked to reschedule my appointment. I also agree that if I miss or cancel any scheduled appointment with less than 24 hours prior notice, I will pay WFPS a $75.00 cancellation fee before a replacement appointment can be rescheduled. I understand that there are no refunds for aesthetic purchases or packages, prepurchases of injectables or aesthetic treatments.

INSUFFICIENT FUNDS
By signing below, I hereby agree that if I have a check returned for insufficient funds, I will pay WFPS the full amount of the returned check, a $35.00 a bad check fee, and any legal fees generated in recovering those funds.

FINANCIAL AGREEMENT
By signing below, I understand all payments and credits expire after 24 months unless otherwise indicated. I hereby agree to pay WFPS their charges for all services rendered during my treatment. I also agree to pay WFPS in full for any and all cosmetic procedures at least three (3) weeks in advance of the scheduled date of service. I understand that WFPS does not accept nor bill insurance for any treatments. I understand that if I elect to request insurance reimbursement on my own that WFPS accepts no responsibility. I also acknowledge and understand that WFPS will not accept responsibility or involvement in negotiating a settlement on any claim.

Patient Signature ___________________________________________ Date __________
Witness ___________________________________________ Date __________
Winslow

Facial Plastic Surgery

Patient Information Questionnaire

Mr./Mrs./Ms./Dr.

Name __________________________________________ Date of Birth ___________ Age ___________

Address __________________________________________ City __________________________

State __________ Zip __________ Sex: M F Marital Status: M S D W Sep

Home Phone __________________ Cell __________________ Work Phone _______________________

School/Employer ____________________________ Occupation __________________________

Height ______ Weight ______ Has your weight changed more than 5 pounds in the past 6 months? Y N

E-mail ______________________________________

Emergency Contact

Name: _______________________________________ Phone: __________________________

Address: ______________________________________

Relationship to Patient: ______________________

Contact and Communications

What is your preferred method of contact? HOME PHONE CELL PHONE EMAIL

May we contact you/confirm appointments via text? Y N

May we contact you/confirm appointments via email? Y N

May we leave a voicemail or message with a family member for appointment reminders? Y N

This office routinely receives phone calls and other communications from a Patient’s family member or friend to get information about an appointment or to make a payment for a procedure.

Do you consent to communication between this office and a designated individual or individuals for scheduling and payment activities? Y N

If yes, please provide the name(s) and relationship(s) of the individual(s):
Would you like to be included in our standard e-mail list to receive news of our events and specials? This list is internal and is not shared with any outside parties without your specific prior authorization. Y N

Patient Healthcare Providers

Please provide a list of all current treating physicians, including your Primary Care Physician:

Physician Name and Address: ________________________________________________________________
Phone: ____________________ Specialty or Type of Practice: ______________________________

Physician Name and Address: ________________________________________________________________
Phone: ____________________ Specialty or Type of Practice: ______________________________

Physician Name and Address: ________________________________________________________________
Phone: ____________________ Specialty or Type of Practice: ______________________________

Physician Name and Address: ________________________________________________________________
Phone: ____________________ Specialty or Type of Practice: ______________________________

Physician Name and Address: ________________________________________________________________
Phone: ____________________ Specialty or Type of Practice: ______________________________

Who is your preferred pharmacy? ________________________________________________________________
Address: _____________________________________________ Phone: ________________________________

Briefly describe the reason for your consultation:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

How did you hear about our office?

_____ WTHR TV      _____ Magazine
_____ FOX 59 TV      _____ indyface.com
_____ Realself.com   _____ Spa/Salon (specify)
_____ Friend (name)  ________________________________________________________________
_____ Doctor (name)  ________________________________________________________________
_____ Other (specify) ________________________________________________________________
CONSENT FOR USE AND DISCLOSURE OF PROTECTED INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _______________________________ DOB: ____________ Telephone: __________________

E-Mail: ______________________________

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to the use and disclosure of certain protected information to carry out treatment, payment activities, and healthcare operations. You will also be consenting to the use and disclosure of your image and contact information for other limited purposes listed below, unless you choose to restrict such use. Your Consent will expire upon the end of the treating physician’s practice of facial reconstructive surgery or your written revocation. There is no expiration of your Consent for the use or disclosure is for the purposes of medical or scientific research of use in Specialty Board examination absent your specific written revocation.

Notice of Privacy Practices: You have been provided a copy of our Notice of Privacy Practices and should review it carefully before you decide whether to sign this Consent. This Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

Right to Revoke: You have the right to revoke this Consent at any time by giving WFPS written notice of your revocation submitted to:

WFPS
2000 E. 116th Street, Suite 200
Carmel, Indiana 46032

The revocation must be signed by you or your legal representative. Please understand that revocation of this Consent will not affect any action WFPS took in reliance on this Consent before it received your revocation.

SECTION C: OTHER USES AND DISCLOSURES

In addition to the use and disclosure of protected health information for treatment, payment, and business operations, WFPS may wish to conduct surveys for purposes of patient satisfaction and quality assurance, seek testimonials from patients for use in public relations and advertising activities and use patient images for promotional purposes. Please initial your consent or refusal to the following:

<table>
<thead>
<tr>
<th>Consent</th>
<th>Refuse</th>
<th>Use or Disclosure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Photographic or video images for promotional and patient information/education in the office</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Photographic or video images for promotional and patient information/education outside of the office, to include social media</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Photographic or video images for medical Specialty Board in formulating its examination of applicant physicians.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Photographic or video images in professional presentations or journal publications by Dr. Winslow</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Contact information for purposes of obtaining patient feedback, including testimonials for use in advertising and publication on various social media and other internet sites.*</td>
</tr>
</tbody>
</table>

*The organization that receives patient contact information has entered into a Business Associate Agreement with WFPS and is required to comply with all HIPAA privacy and security requirements under that Agreement.

SECTION D. SIGNATURE AND ACKNOWLEDGEMENT

I have had a full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand that by signing this Consent form, I am agreeing to the use and disclosure of my protected health information as set forth above.

Signature: ___________________________ Date: ______________

Relationship to Patient: _______________________________
Medical History

List ANY allergies or previous adverse reactions to medications:
_________________________________________________________________________________________

List ALL medications you are taking (including over-the-counter, Herbal Supplements or Vitamins & hormones):
_________________________________________________________________________________________
_________________________________________________________________________________________

Previous Surgeries & Dates

Current Active Illnesses

Are you currently being treated by a psychiatrist?  Yes  No Name________________ Phone________

Have you been diagnosed with:

____ Borderline Personality Disorder   ____ Major Depressive Disorder   ____ Schizophrenia
____ Body Dismorphic Disorder         ____ General Anxiety Disorder

Nicotine/Smoker:  Yes  No  Type/Packs per day________ Alcoholic Drinks per week:  _______________

Do you have a personal history of?

____ Heart Disease     ____ Alcoholism     ____ Heart Attack (date)     ____ Diabetes
____ Tuberculosis      ____ Stroke        ____ Asthma                  ____ Heart Murmur
____ Breathing Problems ____ Chest Pain    ____ Hepatitis/HIV           ____ Nose Bleeds
____ Glaucoma/Eye Disorder  ____ Dry Eyes   ____ Skin Cancer            ____ Arthritis
____ Stomach Problems/Refux  ____ Other Cancer  ____ Headaches            ____ Latex Allergy
____ Pulmonary Edema       ____ Thyroid Prob. ____ Blood Disorders         ____ Seizures/Epilepsy
____ MRSA                 ____ Cold Sores    ____ High Blood Pressure     ____ Varicose Veins
____ Bad Scarring/Keloid   ____ Facial Paralysis ____ Bronchitis/Emphysema / Abnormal Lung Function
____ Mitral Valve Prolapse ____ Chest Pain    ____ Irritable Bowel Disease
____ Immunosuppression    ____ Other Cancer  ____ Blood Clots Pulmonary Edema
____ Easy Bruising or Prolonged Bleeding  ____ Blood Disorders         ____ Previous Post Operative Complications
____ Autoimmune Disease   ____ High Blood Pressure
____ Accutane Use(Past or Present) Date Discontinued ______________

Other

Please specify if you checked any medical history:
________________________________________________________________________

Family history of?

____ Heart Disease     ____ Diabetes     ____ Tuberculosis
____ Stroke            ____ Asthma        ____ Heart Murmur
____ Hepatitis/HIV     ____ Glaucoma/Eye Disorder  ____ Skin Cancer
____ Arthritis         ____ Other Cancer  ____ MRSA
____ Bad Scarring/Keloid  ____ Depression    ____ Mental Illness
____ High Blood Pressure  ____ Seizures     ____ Blood Disorder
____ Easy Bruising or Prolonged Bleeding  ____ Bronchitis/Emphysema  ____ Blood Clots
____ Previous Post Operative Complications
____ Autoimmune Disease
____

Please specify if you checked any medical history:
________________________________________________________________________

10/31/2018
Authorization for Disclosure of Information

Because we offer an in-house surgical suite it is required that we undergo peer review for accreditation purposes. A licensed medical professional will randomly pull charts for evaluation to ensure all standards are met and exceeded. We must obtain authorization for this practice please be assured your information remains protected and is never releases without additional consent.

I authorize Dr. Winslow to disclose complete information concerning her medical findings and treatment of the undersigned, from initial office visit until the date of the conclusion of such treatment, to those individuals who, in Dr. Winslow’s sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

Patient’s Signature_________________________________________ Date________________

Witness____________________________________________________