

J. Daniel Labs, M.D.

Certified, American Board of Surgery (1992-2002), Certified, American Board of Plastic Surgery, Certificate in Hand Surgery
Active Member, American Society of Plastic Surgeons, Active Member, American Association for Hand Surgery

Plastic Surgery

2425 9th Street N., Suite 210, Naples, Florida 34103
Telephone 239-434-5663, Fax 239-261-8526
www.aestheticconsultants.net

Hand and Reconstructive Surgery

720 Goodlette Road, North #205, Naples, Florida 34102
239-649-4263, Fax 239-434-6447
www.handandextremitycenter.com

Sign In Document

Five (5) Signatures Required

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Profile

Patient's Last Name _____ First _____ Middle Initial _____

Date of birth _____ Social Security Number _____

Local Address _____

City _____ State _____ Zip _____ Telephone _____ Cell _____

Secondary Address _____

_____ Telephone _____

Employer's Name/Address (Worker's Compensation) _____

_____ Telephone _____

Guarantor (if not patient) _____ DOB _____ SS# _____

Marital Status _____ Spouse's Name _____ Contact Number _____

How did you hear about Dr. Labs? Physician Friend / Relative Yellow pages Newspaper
Magazine Emergency Room Other _____

Who may we thank for referring you to our office? _____

Have you ever been involved in medical litigation? yes no _____

Insurance: Commercial Medicare Medicaid Worker's comp. Self-pay No-fault

Please provide your insurance cards for us so that we can make a photocopy of them. If this is a worker's compensation injury, please provide us with a Notice of Injury form from your employer, as well as your employer's name, address, and telephone number. We are pleased to assist you in the filing of your insurance. However, each patient is responsible for the payment of his/her own medical bills. Payment is due when services are rendered.

I hereby authorize Dr. J. Daniel Labs to release any information regarding services rendered by him and allow a photocopy of my signature to be used to file insurance. I hereby authorize and direct payment check(s) for benefits due to me for the services rendered by Dr. J. Daniel Labs to be made directly to him. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees for services rendered. If my account is turned over to collection, I agree to pay any additional legal / collection fees incurred.

Signature: _____ **Date:** _____

Medical History

Name _____ Age _____

Describe what problem brings you here: _____

How long has the problem been significant to you? _____

Have you seen another doctor for this condition? yes no

List ALL Medications you are currently taking (including dosage and frequency):

List any Allergies/Reactions: _____ None

List ALL previous surgeries and hospitalizations: _____ None

List ALL medical problems:

List all serious illnesses that occur in your family:

Do you smoke? yes no How much? _____

Do you drink alcohol? yes no How much? _____

Do you bleed easily? yes no

Circle all organ systems that have caused you serious illness:

Brain/Neuro	Cardiovascular	Pulmonary	Genital
Ears/Nose/Throat	Urinary	Musculoskeletal	Breast
Gastrointestinal	Endocrine	Eyes	Other

Explain: _____

I attest that this medical history is true, accurate, and complete. Further, I understand that ANY omissions, falsifications, misrepresentations, or otherwise incorrect information that I provide, regardless of the reason that it is incorrect, may directly affect my medical care and increase my risks of complications. I agree to hold harmless J. Daniel Labs, M.D., and his professional staff, for any actions taken based on false, misleading, incorrect, or incomplete information that I have provided. In addition, I agree to accept full and complete responsibility to inform the office of any changes in my medical history that occur while I am under the care of Dr. Labs.

Signature: _____ **Date:** _____

M.D. Dictation _____ Notes _____

Financial Policy

We are very concerned about the rising costs of healthcare. Please review our financial policy and direct any questions or concerns to our office manager before the doctor sees you.

Medicare

This office accepts Medicare on assignment. The Federal Government regulates all Medicare fees. They are significantly less than the "usual and customary" fees charged by this office. You will be responsible for all deductibles and co-payments. In addition, you are responsible for all services not covered by Medicare. Please note that Medicare does NOT cover medical supplies. You are directly responsible for payment of supply charges to the office.

Medicaid

This office does NOT accept Medicaid.

Private Insurance

Each patient is responsible for his/her medical bills. As a courtesy to you, we are pleased to file your insurance claim with all of the appropriate codes. This will maximize your benefits. However, it should be clearly understood that many insurance carriers reimburse below the "usual and customary" fee schedules. We use many sources at arriving at our fees, and in fact, our fees have DECREASED twice in the last 18 years. All deductibles, co-payments, and differences between your insurance carrier's reimbursement and our fee schedule are the responsibility of the patient. We will be pleased to assist you in appealing to your insurance carrier if there is a large discrepancy between your bill and your benefits. We allow thirty days to receive payment from your insurance carrier. If we have not received payment, you are expected to settle your bill promptly with the office. We reserve the right to collect 1.5-% interest per month on all delayed payments unless you have made specific arrangements with the office manager.

Managed Care

This office participates in many managed care contracts. Each plan has specific rules governing payments, co-payments, and deductibles. Co-payments and deductibles are expected at the time service is rendered.

Worker's Compensation and No Fault

Worker's compensation patients are required to present a notice of injury before they can be seen. We do NOT accept letters of protection as a form of payment in litigation disputes. In such cases, patients are completely responsible for payment at the time service is rendered.

Aesthetic Surgery

Fees for aesthetic surgery are due at least seven business days prior to surgery. Your scheduled time cannot be guaranteed if payment is not received, and all deposits will be forfeited.

Ancillary Medical Services

When your medical care requires pathology, laboratory studies, or radiological examinations, you will receive a separate bill from the facility rendering service. This office refers to the ancillary service facilities that we believe provide the best in medical care for you. Our practice has no financial interest in these facilities, and payment is the individual responsibility of each patient.

The doctor is a partner in the Collier Surgery Center. This facility, separate from the doctor's office, provides ambulatory surgical care. The doctor also maintains privileges at the Naples Community Hospital and North Collier Hospital where surgical care is available.

Package Pricing

In case of financial hardship, this office will work diligently to assist you. We do NOT offer payment plans as the staffing to manage such plans is beyond our capabilities. Credit cards represent the best payment plan as we accept both Visa and Mastercard. Package pricing, at significantly discounted fees, is available. Patients requesting reduced fees or waiver of fees

altogether are expected to accept referral to Social Services of Collier County. This government office is expert in determining financial hardship and assists payment for those truly in need (see below). When patients do not qualify for social services but demonstrate need for reduced fees, global fees to cover visits, surgery, anesthesia, and follow-up will be offered commensurate with the patient's financial abilities.

Experience demonstrates that financial matters are best understood and accepted in advance of surgical care, unless a true emergency exists. We take most seriously our responsibility to care for each and every patient regardless of his or her ability to pay, when seen through the emergency room. In return, we expect good faith on the part of patients requesting discounted fees to work with the office manager to settle all financial matters prior to surgery.

Social Services

We maintain a close working relationship with Social Services of Collier County to assist patients in financial hardship. Please ask the office manager for assistance, as it is advisable to investigate available options BEFORE treatment. Our office always accepts payment from Social Services as full and complete.

Emergency Services

Emergency services in the hospital or emergency room are rendered without payment considerations. Patients receiving emergency services are expected to demonstrate a good faith effort to reconcile their accounts in a timely fashion. Follow-up from an emergency room visit may not constitute emergency service. Patients presenting to the office will be asked to pay or present insurance information when they are seen. Financial hardship cases will not be denied care, but must accept responsibility for assisting the office in settling their account.

Collections

Each patient accepts full and total responsibility for payment of any service rendered through this office. While we are pleased to assist you in filing with your insurance agency, your contract with your insurance agency is completely separate from your responsibility to this office. All delinquent accounts will be subject to a 1.5-% monthly service charge. All delinquent accounts are turned over to collections unless other arrangements are made with the office management. Once the account is in collections, you will be responsible to the collection agency for all bills, service fees, and collection costs.

Payment

All payments are due at the time services are rendered unless your insurance plan specifies otherwise, or you have made arrangements with the manager.

I understand and accept my responsibilities for services rendered by the offices of J. Daniel Labs, M.D.

Signature: _____ **Date:** _____

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 demographic data that can be used to identify you. This is health 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.

I. Uses and Disclosures of Protected Health Information

The OFFICE 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 the *facility* 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 the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription or to a laboratory to order a blood test. We may also disclose protected health information to physicians who may be treating you or consulting with the facility with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

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. For example, we may need to disclose information to your health insurance company to get prior approval for the surgery. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provide to you, we may also need to disclose your protected health information to your health insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. This may include disclosure of demographic information to anesthesia care providers for payment of their services.

C. Operations. We may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of the office and to provide quality care to all patients. Health care operations include such activities as: quality assessment and improvement activities, employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities.

In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

D. Other Uses and Disclosures. As part of 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, to inform you of potential treatment alternatives or

options, to inform you of health-related benefits or services that may be of interest to you, or to contact you to raise funds for the facility or an institutional foundation related to the facility. If you do not wish to be contacted regarding fundraising, please contact our Privacy Officer.

II. 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 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 Suspended 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. We will make this disclosure only 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 health care or public benefits.

E. In Connection With Judicial And Administrative Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected 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 protected 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 facility has a suspicion that your health condition was the result of criminal conduct.
- In an emergency to report a crime.

G. To Coroners, Funeral Directors, and for Organ Donation. We may disclose protected 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 protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

H. For Research Purposes. We may use or disclose your protected 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 protected 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 or safety or to the health and safety of the public.

J. For Specified Government Functions. In certain circumstances, federal regulations authorize the facility to use or disclose your protected 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 facility may release your health information to comply with worker's compensation laws or similar programs.

III. Uses and Disclosures Permitted without Authorization but with Opportunity to Object

We may disclose your protected health information to your family member or a close personal 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 protected health information as described.

IV. 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 taken action in reliance upon the authorization.

V. Your Rights

You have the following rights regarding your health information:

A. The right to inspect and copy your protected health information. You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your surgeon and the facility uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected 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 protected 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 within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must 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.

Please contact our Privacy Officer if you have questions about access to your medical record.

B. The right to request a restriction on uses and disclosures of your protected health information. You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. You may also request that we 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 facility 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 facility does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

C. The right to request to receive confidential communications from us by alternative means or at an alternative location. You 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. Requests must be made in writing to our Privacy Officer.

D. The right to request amendments to your protected health information. You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, 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 have the right to request an accounting of certain disclosures of your protected health information made by the facility. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a facility directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting 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 paper 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 the notice or have agreed to accept this notice electronically.

VI. *Our Duties*

The office 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 protected health information that we maintain. If the facility 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.

VII. Complaints

You have the right to express complaints to the facility and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the facility by contacting the facility's Privacy Officer verbally or in writing, using the contact 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.

VIII. Contact Person

The office'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 facility you may submit a complaint to our Privacy Officer by sending it to:

Doris Castronova, Office Manager
720 Goodlette Road, North, Suite 205
Naples, Florida 34102
ATTN: Privacy Officer

The Privacy Officer can be contacted by telephone at 239-649-4263

IX. Effective Date

This Notice is effective April 14, 2003.

Acknowledgement of Receipt of Privacy Notice

I acknowledge that I have received the attached Privacy Notice.

Signature: _____ **Date:** _____

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _____

Plastic, Reconstructive, and Hand Surgery and Treatments

General Information

1. Treatments and procedures in plastic surgery may be reconstructive or cosmetic in nature. Insurance benefits generally apply when an abnormality is treated. Insurance benefits do NOT apply when a normal feature is treated solely for aesthetic improvement.
2. Treatments and procedures for disorders of the hand, extremities, and reconstructive surgeries are considered necessary and reparative in nature. Therefore, insurance benefits, if any, should apply.
3. Realistic expectations are a part of any treatment and surgical procedure.

Goals

1. Reconstruction and repair
2. Pain relief
3. Improvement in appearance
4. Improvement in function
5. Correction of abnormality
6. Cancer or tumor treatment

Limitations of Treatments and Procedures

Delicate structures of the face, body, and hand will always be affected by inflammation and scarring. Natural wound healing involves both of these processes. Scars from treatment can often be limited, but in general, cannot be eliminated. Everyone heals differently, and to a certain extent, unpredictably.

Therapy is often necessary to re-build motion and function following hand or reconstructive treatments. Although the intent of many hand treatments and procedures is to restore the hand to normal, some functional loss and discomfort are typical with most disorders.

Alternatives to Plastic Surgery

Most often, the alternative to a surgical solution for a plastic surgical problem involves topical treatment, or no treatment.

Alternatives to Hand and Reconstructive Surgery

Most often, the alternative to a surgical solution for a hand or reconstructive problem involves conservative care with therapy, bracing, and medications. Conservative care typically limits hand function to a significant degree. In some cases, the hand problem will progress causing irreparable damage when surgery is not performed. Alternatives to skin cancer surgery may involve topical treatment or radiation therapy.

Procedure Details when Surgery is necessary

1. Facility: Plastic, Reconstructive, and Hand Surgery are routinely performed on an outpatient basis.
2. Anesthesia: The anesthesia required may be local and sedation or general anesthesia; local anesthesia only is possible for small procedures.
3. Incisions: Incisions are required, but many new techniques and instruments have been developed to limit the necessary size of the incisions.
4. Dressings: A dressing, ace wrap, sling, and often a splint are required after most hand surgeries. The length of time these must be in place is specific to the particular procedure and varies from 2 days to 8 weeks or longer.
5. Post-operative Care: Recovery at home requires a companion for at least 24 hours; Dr. Labs is on active staff at Naples Community Hospital, North Collier Hospital, and Physician's Regional Medical Center should admission ever be necessary. X-rays and other tests may be necessary and required to achieve anticipated results or to manage complications. Follow up with the doctor at appropriate intervals is necessary and essential to achieving a

successful outcome and/or managing complications. Failing follow up is against medical advice and the doctor cannot accept responsibility for your outcome if you fail follow up.

6. Activities: Detailed instructions will be given to you at the time of your surgery. Gentle activities only are a must until your first post-operative visit. Return to work or athletic activities may require 6 weeks or longer depending on your procedure.

Temporary Expectations

Discoloration, swelling, discomfort, numbness, stiffness, and restricted activity are expected following injury, hand surgery, and/or reconstructive surgery. Fairly rapid resolution of most post-injury and post-surgery changes is anticipated, but your final healing is dependent on the nature and extent of your problem and the procedure required for treatment. Patients who are actively employed will receive a release from work until their first post-operative visit when surgery is required. Typically, patients may return to work in a light duty capacity thereafter. Work restrictions are also applied for non-surgical treatments and when patients are injured. In the early post-operative period or when injury has occurred, or when otherwise restricted, you may not be able to safely drive a vehicle or work with machinery. This is especially important while you are requiring narcotic pain medications. Casts, splints, bandages, slings, and other devices necessary during treatment and after hand surgery restrict motion and function. Driving a vehicle or operating machinery with any of these devices in place can be dangerous and is not recommended. Patients who drive a vehicle or operate machinery before they are instructed do so against the advice of the doctor and accept the complete risk of their actions.

Permanent Expectations

Scars will persist after injury or surgery, but generally fade to an acceptable level with time (6 –12 months). Redness, however, may persist beyond this time, especially in sun-exposed areas. Other permanent changes may be expected that are unique to individual treatments.

Permanent changes in the hand may be expected that are unique to the specific injury sustained or procedures required. Nerve injuries are not usually expected to recover completely. Arthritis cannot be completely cured by surgery or other treatments. Symptoms in patients with arthritis may persist or increase following injury or hand surgery. Worker's Compensation patients will be cared for until their problem has reached Maximum Medical Improvement. At that time, a Permanent Impairment Rating according to Florida State Guidelines will be determined.

Risks/Complications

Bleeding, infection, anesthesia, pain, problematic scarring, deformity, functional limitations, failure to achieve expectations, need for further surgery, loss of sensation, and loss of strength can occur with surgery.

Mental Health Disorders and Elective Surgery

It is important that all patients seeking to undergo elective surgery have realistic expectations that focus on improvement rather than perfection. Complications or less than satisfactory results are sometimes unavoidable, may require additional surgery and often are stressful. Please openly discuss with your surgeon, prior to surgery, any history that you may have of significant emotional depression or mental health disorders. Although many individuals may benefit psychologically from the results of elective surgery, effects on mental health cannot be accurately predicted.

Female Patient Information

It is important to inform your plastic surgeon if you use birth control pills, estrogen replacement, or if you believe you may be pregnant. Many medications including antibiotics may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. Antibiotics are routinely administered at surgery.

Intimate Relations After Surgery

Surgery involves coagulating of blood vessels. Increased activity of any kind may open these vessels leading to a bleed, or hematoma. Increased activity that increased your pulse or heart rate may cause additional bruising, swelling, and the need for return to surgery and control of bleeding. It is wise to refrain from sexual activity until your physician states it is safe.

Medications

There are many adverse reactions that occur as the result of taking over the counter, herbal, and/or prescription medications. Be sure to check with your physician about any drug interactions that may exist with medications which you are already taking. If you have an adverse reaction, stop the drugs immediately and call your plastic surgeon for further instructions. If the reaction is severe, go immediately to the nearest emergency room. When taking the prescribed pain medications after surgery, realize that they can affect your thought process. Do not drive, do not operate complex equipment, do not make any important decisions and do not drink any alcohol while taking these medications. Be sure to take your prescribed medication only as directed.

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 dying, delayed healing, and additional scarring. Individuals exposed to second-hand smoke are also at potential risk for similar complications attributable to nicotine exposure. Additionally, smokers may have a significant negative effect on anesthesia and recovery from anesthesia, with coughing and possibly increased bleeding. Individuals who are not exposed to tobacco smoke or nicotine-containing products have a significantly lower risk of this type of complication.

It is important to refrain from smoking at least 6 weeks before elective surgery and until your physician states it is safe to return, if desired.

Patient Compliance

Follow all physician instructions carefully. This is essential for the success of your outcome. It is important that the surgical incisions are not subjected to excessive force, swelling, abrasion, or motion during the time of healing. Personal and vocational activity need to be restricted. Protective dressings and drains should not be removed unless instructed by your plastic surgeon. Successful post-operative function depends on both surgery and subsequent care. Physical activity that increases your pulse or heart rate may cause bruising, swelling, fluid accumulation and the need for return to surgery. It is wise to refrain from intimate physical activities after surgery until your physician states it is safe. It is important that you participate in follow-up care, return for aftercare, and promote your recovery after surgery.

Financial Responsibilities

The cost of surgery involves several charges for the services provided. The total includes fees charged by your surgeon, the cost of surgical supplies, anesthesia, laboratory tests, and possible outpatient hospital charges, depending on where the surgery is performed. Depending on whether the cost of surgery is covered by an insurance plan, you will be responsible for necessary co-payments, deductibles, and charges not covered. The fees charged for this procedure do not include any potential future costs for additional procedures that you elect to have or require in order to revise, optimize, or complete your outcome. Additional costs may occur should complications develop from the surgery. Secondary surgery or hospital day-surgery charges involved with revision surgery will also be your responsibility. In signing the consent for this consultation, you acknowledge that you have been informed about its risk and consequences and accept responsibility for the clinical decisions that were made along with the financial costs of all future treatments.

Comments

1. Any and all of the risks and complications can result from injury or surgery. When complications occur, additional treatment or surgery, time off work, hospitalization, and expense may be incurred. Even though the risks and complications cited above do not often occur, they are the ones that are of greatest concern for plastic, reconstructive, or hand surgery. Other complications and risks can occur, but are even more uncommon. You can reduce your risk by closely following your surgeon's advice both before and after surgery. Follow-up is critical to both avoiding complications and correcting complications when they occur. Do not hesitate to schedule additional follow-up examinations or to contact the doctor/doctor's office directly if you believe a complication has occurred. Dr. Labs cannot accept continuing responsibility for your care if you do not follow-up as directed.
2. On occasion, surgical revision may be necessary following the original surgery.
3. The practice of medicine and surgery is not an exact science. Although good results are expected, there cannot be any guarantee, nor warranty, expressed or implied, by anyone as to the results that may be obtained.
4. Smoking is hazardous to your health. It increases the risk of scarring, poor healing, hair loss, and most importantly skin loss due to circulation deprivation. We recommend strongly that smoking be discontinued. Your risk of complications from surgery will be directly related to your smoking history and continuation of the habit. Smokers and patients who have recently quit smoking must fully accept the additional risk of complications from surgery.
5. Aspirin and aspirin-containing products affect blood clotting. Non-steroid anti-inflammatory agents (NSAIA), excessive ingestion of Vitamin E, and certain dietary deficiencies may have the same effect. If you are taking aspirin, aspirin-containing medications, NSAIA's, Vitamin E, anti-coagulants or any other medication known to affect blood clotting, or if you have any other reason to believe that your blood clotting may be abnormal, please disclose this completely to the doctor. Most often, you will be instructed to CONTINUE aspirin, aspirin-containing products, and NSAIA's if they have been prescribed by a physician for a specific reason. If you are using these medications for analgesia only (pain relief), please discontinue them two weeks prior to surgery. Tylenol (acetaminophen) does NOT affect blood clotting and is acceptable in the immediate pre-operative period. Patients taking anti-coagulant medications need specific instructions from the doctor. Complications from bleeding after your procedure can be dangerous and to minimize your risk, directions on medications must be followed closely. Your surgery may be cancelled if medications have been taken in error. When medications affecting blood clotting have been prescribed for heart disease, brain circulation, or peripheral vascular disease, the risk of discontinuing the medication may outweigh the risk of bleeding from plastic surgery. Please check your current medications to avoid unnecessary problems. Surgery around this eye represents the most typical circumstance in plastic surgery where coagulation must be normalized by cessation of ANY medications that can prolong bleeding prior to surgery.
6. We encourage you to carefully read over this consult sheet. Please mark any information that you wish to further discuss. The doctor and staff is available to you answer all of your questions. A formal consent form will be presented to you prior to surgery, when necessary, which contains additional information for your review.

Consent to Evaluate and Treat

I hereby authorize J. Daniel Labs, M.D. and such assistants as may be selected, to evaluate my condition, to make treatment recommendations, and to commence treatment.

I recognize that during the course of the evaluation and medical treatment that unforeseen conditions may necessitate different treatments to be recommended. I therefore authorize the above physician and assistants or designees to exercise his or her professional judgment as is necessary and desirable to treat my condition. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician at the time treatment is begun.

I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.

I understand that J. Daniel Labs, M.D. is a Board-Certified Plastic Surgeon and that his practice is limited to the disciplines of Plastic, Reconstructive, and Hand Surgery. I hereby release Dr. Labs from any and all responsibility for the diagnosis and/or treatment of any conditions that I may have outside the scope of his specialty practice.

I have read, and I understand, all of the sections of the sign in documents. I have recorded my profile and medical history completely and accurately. All of my questions regarding the sign in documents have been answered in a manner that I understand.

I agree to review thoroughly all written materials presented to me during my evaluation and treatment and to ask any question that I may have before my treatment begins or surgery is required.

Patient's Signature _____ **Date** _____

Witness

This sign in package has been presented, in its entirety, to the patient and includes:

1. Profile
2. Medical History
3. Financial Policy
4. Privacy Policy
5. Consultation

The patient has signed all five sections of the sign in documents.

The patient desires to initiate a doctor-patient relationship with J. Daniel Labs, M.D., Board Certified Plastic Surgeon, practicing in Naples, Florida.

The patient has been given a copy of the sign in documents or understands that they are viewable on the web.

The patient has been given the opportunity to ask questions about the sign in documents. All of the patient's questions concerning the documents have been answered in a manner that the patient understands.

Witness Signature _____ **Date** _____