FACIAL PLASTIC
SURGERY CENTER
A division of Otolaryngology Associates, PC

AGREEMENT FOR SERVICES

Date: ____________________

1. ____________________________ (“Patient”) seeks to have the following surgical procedures performed by __________________________________ (“Surgeon”) and Otolaryngology Associates, P.C. (“The Association”) including:____
   ____
   (“The Operation).

2. The Patient has been fully informed by the Surgeon and/or the Association regarding the effect and nature of the Operation to be performed, the reasonable and foreseeable risks, as well as the possible alternative methods of treatment.

3. The Patient has been fully informed that the Operation may require the administration of anesthetics and that said anesthetics involve additional risks and hazards, but the Patient requests the use of anesthetics for relief and protection from pain during any procedures. The Patient realizes also that anesthesia may have to be changed, possibly without explanation to the Patient.

4. The Patient understands that the practice of medicine and surgery is not an exact science and therefore reputable practitioners cannot guarantee results.

5. The Operation may be accomplished through external incisions (cuts) in the skin which will leave permanent scars and the Patient has been fully informed as to the extent, nature and location of these scars.

6. The Operation may require a medical grade implant and the Patient has been fully informed as to the possible risks associated with said implant as well as alternative methods of treatment.

7. The Patient has been given an opportunity to ask questions about the Patient’s condition, alternative forms of anesthesia and treatment, risk of non-treatment, the procedures to be used and the risks and hazards involved, and the Patient believes that the Patient has sufficient information to give this informed consent.

8. Patient requests and authorizes the Surgeon and the Association to perform the above referenced Operation upon the Patient on or about the ____ day of _______________, ________.

9. The Patient also authorizes the Surgeon and/or any qualified Association employee to perform any other procedures he or she may deem necessary or desirable in attempting to complete the operation, and/or treat any unhealthy and/or unforeseen condition that may be encountered during the Operation. Patient also agrees to reimburse the Surgeon and/or the Association for any costs incurred under this provision and not included in Paragraph 10 below.

10. The Patient agrees to pay the Surgeon's fee which is ______________________________________ ___________________ ($________________) at least two weeks prior to the date of the Operation.

11. The Patient acknowledges that the Surgeon's time is valuable and by agreeing to perform the Operation on the specified date the Surgeon will be unable to treat other individuals during this time. As such, the Patient agrees that if the Patient cancels said operation:

    - at least seven (7) days prior to the date of surgery only fifty percent (50%) of the prepaid fee shall be refunded;
    - if Patient cancels said Operation at least three (3) days prior to the Operation then only twenty-five (25%) of the prepaid fee shall be refunded; and
    - if the Patient cancels within three days (3) days before the surgery no money shall be refunded.

    Cancellation shall include the failure to appear for the Operation.

12. Surgeon has discussed with Patient, whether the operation is a service paid for by their HMO/Insurance Plan. Patient understands that if their HMO/Insurance Plan does not pay for the operation, Patient will be financially liable for the cost of the operation.

13. The Patient agrees and consents to the taking and medical publication of photographs of the Patient and Operation if in the judgment of the Surgeon or Association, medical research or education will benefit by their use.

14. The Patient, having been fully informed by the Surgeon and the Association of the hazards and possible consequences involved in the Operation, consents to such treatment and agrees to hold the Surgeon and the Association free and harmless of any claims, demands, or suits for damages from any injury or complications whatever, save negligence, that may result from such treatment.

15. The Patient certifies that the information contained herein has been fully explained to the Patient, that the Patient has read it or has had it read to the Patient, that the blank spaces have been filled in and that the Patient understands its contents.

Signature____ Date:_______________
(Patient or Person Authorized to Give Consent for Patient)

Printed Name ____

Relationship to Patient_______________________________________

Witness Signature____ Date:_______________
(Not a member of the family)

Printed Witness Name_______________________________________