STURM
COSMETIC SURGERY
Beautifully You

Cancellation Policy

EFFECTIVE DATE: **01.2019**

LAST REVISED DATE: **6.14.2023**

NUMBER OF PAGES: **2**

PURPOSE: To develop cancelation guidelines for surgical and clinical patients and ensure that each patient understands these guidelines prior to scheduling a surgical procedure or clinical treatment/consultation and paying a deposit.

Patients who visit Sturm Cosmetic Surgery will receive a copy of this Cancellation Policy. Upon receipt of the policy, each patient shall sign the Cancellation Policy, stating he or she understands and agrees to this policy, as amended, or updated by Sturm Cosmetic Surgery.

Clinical Cancellation Policy

- A credit card must be on file within 24 hours of your appointment. This is to reserve your appointment only and will not be charged without notice.
- If you cancel your appointment without a 24-hour notice, your credit card **will** be charged **50%** of your scheduled treatment or procedure cost or **$50** for clinical and surgical consultations, and injectable appointments. These fees are non-refundable and will not be applied to any future treatments.
- A "No Show", is defined as a patient arriving 15 minutes or more late to their scheduled appointment time or as a patient that fails to show for their appointment and **will** result in a charge of **50%** of your scheduled treatment or procedure cost or **$50** for clinical and surgical consultations, and injectable appointments. These fees are non-refundable and will not be applied to any future treatments.

Surgical Cancellation Policy

- Your final balance, paid in full, is due three (3) weeks prior to your surgery date and is **non-refundable**. If payment is not received three (3) weeks prior to your planned procedure, your surgery may be postponed or cancelled. If you would like to reschedule your procedure less than two (2) weeks prior to your surgery date, a **rescheduling fee**, **up to 30% of your total fees** will apply.
- All patients must complete their pre-operative appointment and submit all necessary labs (including EKG, Mammogram, and medical clearance if requested by the surgeon) at least three (3) weeks prior to your surgery. It is your responsibility to notify our office if your contact information changes or needs to be updated. We will attempt to contact you three (3) times, if we are unable to reach you within 72 hours of our first attempt, then we reserve the right to cancel your surgery. If you wish to reschedule for a future date, a rescheduling fee may apply.
- Testing for nicotine and illicit drugs (including weight loss pills) are routinely performed on patients the day of surgery. Should you test positive, refuse to be tested or decide not to follow the instructions given to you by our clinical staff, then we reserve the right to cancel your procedure for that day. If you believe the test results are inaccurate, then you the right to submit a blood test. If the blood test is **negative,** then you **will not** be charged a rescheduling fee. If your test is **positive** and your case must be canceled the day of your surgery, a rescheduling fee will apply, **up to 30% of your total fees**.
- You must have an adult caregiver (minimum 18 years of age and aware of your surgical procedures) with you at all times for the first 24 hours after your surgery. If you do not have an appropriate caregiver with you at the time of your surgery, we may cancel your procedure and a rescheduling fee will apply, up to 30% of your total fees.
- You are required to stay within an hour of Sturm Cosmetic Surgery for the first 24 hours after your surgery.
- If you cancel your surgery without a 24-hour notice, you **will** be charged a rescheduling fee, **up to 30% of your total fees**, to reschedule your surgery, and your surgical balance is **non-refundable**. **if there are emergencies which cannot be prevented, no rescheduling fee will apply

Patient signature___________________________________Date___________________________

Witness signature__________________________________Date___________________________

HIPAA NOTICE OF PRIVACY PRACTICES

<u>THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.</u>

<u>PLEASE REVIEW IT CAREFULLY.</u>

Sturm Cosmetic Surgery and its employees are dedicated to maintaining the privacy of your personal health information, as required by applicable federal and state laws. These laws require us to provide you with this Notice of Privacy Practices, and to inform you of your rights and our obligations concerning Protected Health Information, or PHI, which is information that identifies you and that relates to your physical or mental health condition. We are required to follow the privacy practices described below while this Notice is in effect.

<u>A. Permitted Disclosures of PHI</u>. We may disclose your PHI for the following reasons:

1. **<u>Treatment</u>**. We may disclose your PHI to a physician or other health care provider providing treatment to you. For example, we may disclose medical information about you to physicians, nurses, technicians or personnel who are involved with the administration of your care.

2. **<u>Payment</u>**. We may disclose your PHI to bill and collect payment for the services we provide to you. For example, we may send a bill to you or to a third party payor for the rendering of services by us. The bill may contain information that identifies you, your diagnosis and procedures and supplies used. We may need to disclose this information to insurance companies to establish insurance eligibility benefits for you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims.

3. **<u>Health Care Operations</u>**. We may disclose your PHI in connection with our health care operations. Health care operations include quality assessment activities, reviewing the competence or qualifications of health care professionals,

evaluating provider performance, and other business operations. For example, we may use your PHI to evaluate the performance of the health care services you received. We may also provide your PHI to accountants, attorneys, consultants and others to make sure we comply with the laws that govern us.

4. **Emergency Treatment**. We may disclose your PHI if you require emergency treatment or are unable to communicate with us.

5. **Family and Friends**. We may disclose your PHI to a family member, friend or any other person who you identify as being involved with your care or payment for care, unless you object.

6. **Required by Law**. We may disclose your PHI for law enforcement purposes and as required by state or federal law. For example, the law may require us to report instances of abuse, neglect or domestic violence; to report certain injuries such as gunshot wounds; or to disclose PHI to assist law enforcement in locating a suspect, fugitive, material witness or missing person. We will inform you or your representative if we disclose your PHI because we believe you are a victim of abuse, neglect or domestic violence, unless we determine that informing you or your representative would place you at risk. In addition, we must provide PHI to comply with an order in a legal or administrative proceeding. Finally, we may be required to provide PHI in response to a subpoena discovery request or other lawful process, but only if efforts have been made, by us or the requesting party, to contact you about the request or to obtain an order to protect the requested PHI.

7. **Serious Threat to Health or Safety**. We may disclose your PHI if we believe it is necessary to avoid a serious threat to the health and safety of you or the public.

8. **Public Health**. We may disclose your PHI to public health or other authorities charged with preventing or controlling disease, injury or disability, or charged with collecting public health data.

9. **Health Oversight Activities**. We may disclose your PHI to a health oversight agency for activities authorized by law. These activities include audits; civil, administrative, or criminal investigations or proceedings; inspections; licensure or disciplinary actions; or other activities necessary for oversight of the health care system, government programs and compliance with civil rights laws.

10. **Research**. We may disclose your PHI for certain research purposes, but only if we have protections and protocols in place to ensure the privacy of your PHI.

11. **Workers' Compensation**. We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs.

12. **Specialized Government Activities**. If you are active military or a veteran, we may disclose your PHI as required by military command authorities. We may also be required to disclose PHI to authorized federal officials for the conduct of intelligence or other national security activities.

13. **Organ Donation**. If you are an organ donor, or have not indicated that you do not wish to be a donor, we may disclose your PHI to organ procurement organizations to facilitate organ, eye or tissue donation and transplantation.

14. **Coroners, Medical Examiners, Funeral Directors**. We may disclose your PHI to coroners or medical examiners for the purposes of identifying a deceased person or determining the cause of death, and to funeral directors as necessary to carry out their duties.

15. **Disaster Relief**. Unless you object, we may disclose your PHI to a governmental agency or private entity (such as FEMA or Red Cross) assisting with disaster relief efforts.

B. **Disclosures Requiring Written Authorization**.

1. **Not Otherwise Permitted**. In any other situation not described in Section A above, we may not disclose your PHI without your written authorization.

2. **Psychotherapy Notes**. We must receive your written authorization to disclose psychotherapy notes, except for certain treatment, payment or health care operations activities.

3. **Marketing and Sale of PHI**. We must receive your written authorization for any disclosure of PHI for marketing purposes or for any disclosure which is a sale of PHI.

C. **Your Rights**.

1. **Right to Receive a Paper Copy of This Notice**. You have the right to receive a paper copy of this Notice upon request.

2. **Right to Access PHI**. You have the right to inspect and copy your PHI for as long as we maintain your medical record. You must make a written request for access to the Compliance Officer at the address listed at the end of this Notice. We may charge you a reasonable fee for the processing of your request and the copying of your medical record pursuant to applicable state and federal law. In certain circumstances we may deny your request to access your PHI, and you may request that we reconsider our denial. Depending on the reason for the denial,

another licensed health care professional chosen by us may review your request and the denial

3. **Right to Request Restrictions**. You have the right to request a restriction on the use or disclosure of your PHI for the purpose of treatment, payment or health care operations, except for in the case of an emergency. You also have the right to request a restriction on the information we disclose to a family member or friend who is involved with your care or the payment of your care. However, we are not legally required to agree to such a restriction.

4. **Right to Restrict Disclosure for Services Paid by You in Full**. You have the right to restrict the disclosure of your PHI to a health plan if the PHI pertains to health care services for which you paid in full directly to us.

5. **Right to Request Amendment**. You have the right to request that we amend your PHI if you believe it is incorrect or incomplete, for as long as we maintain your medical record. We may deny your request to amend if (a) we did not create the PHI, (b) is not information that we maintain, (c) is not information that you are permitted to inspect or copy (such as psychotherapy notes), or (d) we determine that the PHI is accurate and complete.

6. **Right to an Accounting of Disclosures**. You have the right to request an accounting of disclosures of PHI made by us (other than those made for treatment, payment or health care operations purposes) during the 6 years prior to the date of your request. You must make a written request for an accounting, specifying the time period for the accounting, to the Compliance Officer at the address listed at the end of this Notice.

7. **Right to Confidential Communications**. You have the right to request that we communicate with you about your PHI by certain means or at certain locations. For example, you may specify that we call you only at your home phone number, and not at your work number. You must make a written request, specifying how and where we may contact you, to the Compliance Officer at the address listed at the end of this Notice.

8. **Right to Notice of Breach**. You have the right to be notified if we or one of our business associates become aware of a breach of your unsecured PHI.

D. **Changes to this Notice**. We reserve the right to change this Notice at any time in accordance with applicable law. Prior to a substantial change to this Notice related to the uses or disclosures of your PHI, your rights or our duties, we will revise and distribute this Notice.

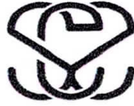
E. **Acknowledgment of Receipt of Notice**. We will ask you to sign an acknowledgment that you received this Notice.

F. **Questions and Complaints.** If you would like more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made regarding the use, disclosure, or access to you PHI, you may notify us of this concern by contacting the Compliance Officer at the address and phone number at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request.

We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to:

Dr. Lindsay J Sturm. 2722 Aspen Rd Ste 101 Ames IA 50010. #515.292.2480



STURM

COSMETIC SURGERY

Beautifully You

New Patient Information

Date: ___________________

Name: ____
Address____
City_________________________________ State______________ Zip __________________
Email address____ SS#_______________________
Home phone_________________________________ Mobile phone________________________
Preferred method of contact?_________________________ May we leave a message_________
Date of birth___________________________________ Age__________ Sex_______________
Marital status________________ Height______________ Weight_______________________
Race: Caucasian_____ African American______ Hispanic______ Asian_____ Other_________
Primary Language _____________________ Secondary language ________________________
Emergency Contact: ____
Phone number: ____________________________ Relationship: ________________________

How did you hear about the office: friend________ (friend's name_______________________), tv ______, Radio______ (station_____________), Website _______(name of website________________), Newspaper______, Magazine_______(name of magazine_______________), Other_________(please explain_____________________________)

What products are you currently using on your face?__________________________________
____

Do you wear sunscreen?______________________
How would you describe your skin?

_____Always burn, never tan
_____Always burn, sometimes tan
_____Sometimes burn, always tan
_____Never burn, always tan

Do you have any skin allergies or hypersensitivity? If yes, please explain __________________
____

Have you ever used or had

_____Retin A
_____Chemical Peels
_____Microdermabrasion
_____Laser, type_________
_____Herpes (or cold sore)
_____Accutane
_____Oral Contraceptives

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Patient Health History

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish. There is room to explain your answers more completely on the back of the second page. **Please print or type**.

Name________________________________ Date of Birth _________ Age_______
Address____
Occupation__________________________________ Cell phone____________________
Email____
Emergency Contact_____________________________Phone_______________________
How did you hear about us?____

Procedures I would like to discuss with the doctor
____
____

Pharmacy preference_____________________________ Phone_______________________

Medications

Medication Name	Dose	How Often Taken

Allergies

Medication Name	Type of Reaction

Do you have any environmental allergies? [ ] Yes [ ] No Please list_____________________
Do you have food allergies? [ ] Yes [ ] No Please list_______________________________
Do you have an allergy to Latex? [ ] Yes [ ] No

Past Medical History—have you ever been diagnosed with any of these problems?

	Yes	No	Year	Comments
Cancer (please list type)				
Cardiovascular				
Do you have a pacemaker?	[ ]	[ ]		
High/Elevated Cholesterol?	[ ]	[ ]		
High Blood Pressure?	[ ]	[ ]		
Other Heart Concerns?	[ ]	[ ]		
Respiratory				
Asthma	[ ]	[ ]		
COPD	[ ]	[ ]		
Tuberculosis	[ ]	[ ]		
Gastrointestinal				
Hepatitis	[ ]	[ ]		
Reflux	[ ]	[ ]		
Stomach Ulcers	[ ]	[ ]		
Kidney				
Renal Failure	[ ]	[ ]		
Mental and Emotional				
Depression/anxiety	[ ]	[ ]		
(requiring treatment)	[ ]	[ ]		
Hematologic/immunity				
Anemia	[ ]	[ ]		
HIV/AIDS	[ ]	[ ]		
Hepatitis	[ ]	[ ]		
Mononucleosis	[ ]	[ ]		
Bleeding after surgery	[ ]	[ ]		
Blood transfusions	[ ]	[ ]		
Clotting disorder	[ ]	[ ]		
Endocrine				
Diabetes	[ ]	[ ]		
Thyroid disorder	[ ]	[ ]		

Gynecologic History (Women, please complete the following)

	Yes	No	Comment
Menses/Pregnancies/Births Could you be pregnant? Date of last period?______ # of Pregnancies_____ # of live births______ Current contraceptive use________	[ ]	[ ]	
Nursing Are you nursing? How many months total have you nursed?______	[ ]	[ ]	
Hormone History Have you ever taken Hormones? Number of years taking hormones?_______	[ ]	[ ]	
Breast Health-have you ever had: Bloody nipple discharge Non-bloody nipple discharge Injury to your breasts? Breast infections? Pain in breasts: Breast biopsy?	[ ] [ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ] [ ]	
Breast Cancer Risk Profile Do you consider yourself: • Caucasian/non-black • Hispanic • Black Date of last mammogram________ Result: Age at first live birth?_____ Number of mother/sisters/daughters with breast cancer______ Number of previous breast biopsies_________			
Vaginal Rejuvenation: Do you suffer from urinary leakage? Do you suffer with vaginal dryness/irritation? Are you concerned with vaginal laxity? Do you have discomfort during intercourse? Any decrease in libido/sexual function?	[ ] [ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ] [ ]	

Are you Diabetic? Yes No

If so, what medication do you take?____

____

Have you ever been hospitalized for a medical problem before? Yes No

If so, what? ____

____

Past Surgical History

Year	Surgery	Physician

Anesthesia History:

Have you ever had any problems with anesthesia? Yes No

If yes, please explain: ____________________

Additional Anesthesia Questions	Yes	No	Comments
Do you have personal or family history of unexpected death following general anesthesia or exercise?	[ ]	[ ]	
Any personal or family history of Malignant Hyperthermia?	[ ]	[ ]	
A muscle or neuromuscular disorder?	[ ]	[ ]	
High temperature following exercise?	[ ]	[ ]	
A personal history of muscle spasm?	[ ]	[ ]	
Dark or chocolate colored urine?	[ ]	[ ]	
Unanticipated fever immediately following anesthesia?	[ ]	[ ]	

Family History—Please mark all that apply

	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Specific Anesthesia Problem								
Cancer (please list type under check mark)								
Hypertension Heart Concerns	[ ] [ ]	[ ] [ ]	[ ] [ ]	[ ] [ ]	[ ] [ ]	[ ] [ ]	[ ] [ ]	[ ] [ ]
Asthma								
Stroke								
Bleeding or clotting disorder								

Social History

	Yes	No	Comments
Have you smoked in the past? Do you smoke now? Have you used ANY nicotine in the last 3 months?	[ ] [ ] [ ]	[ ] [ ] [ ]	
Do you drink alcohol?	[ ]	[ ]	
Do you use any recreational drugs?	[ ]	[ ]	

Review of Systems—Have you RECENTLY had any of the following problems?

	Yes	No	Comments
General health problems:			What is your current height:__________ Weight:_________
Fever	[ ]	[ ]	
Chills	[ ]	[ ]	
Night Sweats	[ ]	[ ]	
Weight loss/gain > 10lbs/1month	[ ]	[ ]	
Fatigue	[ ]	[ ]	
Head/neck problems:			
Vision/eye problems	[ ]	[ ]	
Earache/loss of hearing	[ ]	[ ]	
Chronic sinus infections	[ ]	[ ]	
Cardiovascular problems:			
Fainting	[ ]	[ ]	
Chest pain	[ ]	[ ]	
Irregular heartbeat/palpitations	[ ]	[ ]	
Swelling of ankles	[ ]	[ ]	
Respiratory problems:			
Frequent non-productive cough	[ ]	[ ]	
Frequent productive cough	[ ]	[ ]	
Shortness of breath	[ ]	[ ]	
Short of breath climbing 1 flight of stairs	[ ]	[ ]	
wheezing	[ ]	[ ]	
Gastrointestinal problems:			
Difficulty swallowing/food stuck in throat	[ ]	[ ]	
Abdominal pain	[ ]	[ ]	
Constipation or diarrhea	[ ]	[ ]	
Heartburn	[ ]	[ ]	
Nausea/ vomiting	[ ]	[ ]	
Blood in stools/ black, tar-like stools	[ ]	[ ]	
Neurologic problems:			
Numbness/Tingling	[ ]	[ ]	
Seizures	[ ]	[ ]	
Weakness	[ ]	[ ]	
Urologic problems:			
Blood in urine	[ ]	[ ]	
Difficulty starting urine stream	[ ]	[ ]	
Burning on urination	[ ]	[ ]	
Leaking of urine	[ ]	[ ]	
Mental and emotional problems:			
Depression (requiring treatment)	[ ]	[ ]	
Anxiety (requiring treatment)	[ ]	[ ]	
Endocrine problems:			
Temperature fluctuations	[ ]	[ ]	
Diabetes or family history of diabetes	[ ]	[ ]	
Thyroid disease	[ ]	[ ]	
Hematologic problems:			
Swollen lymph nodes	[ ]	[ ]	
Bruising easily	[ ]	[ ]	
Skin problems:			
Autoimmune disorders	[ ]	[ ]	
Itching	[ ]	[ ]	
Rash	[ ]	[ ]	
burns	[ ]	[ ]	

Signature:_______________________________________ Date:_________________________

STURM
COSMETIC SURGERY
Beautifully You

PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ____ DOB: ___________

Patient ID: ____

I, the above-named patient, acknowledge that I have had the opportunity to review Sturm Cosmetic Surgery's HIPAA Notice of Privacy Practices. I have read and understand the terms set forth in such Notice. Furthermore, I understand that Sturm Cosmetic Surgery reserves the right to amend the Notice at its discretion and to comply with applicable state and federal law.

_________________________________ _________________________________

Patient Signature Date

STURM
COSMETIC SURGERY

Beautifully You

Consent for Smokers and Second-Hand Smoke Exposure

Patient Name: ______________________________________ DOB: ______________

Patient ID: ____

Patients who smoke or use tobacco products or other nicotine products (chewing tobacco, patch, gum, vapor, nasal spray, e-cigarrettes, or other types of smokeless tobacco) are at a greater risk for significant surgical complications including skin necrosis, delayed healing, and additional scarring. Individuals exposed to second-hand smoke are also at potential risk for similar complications attributable to tobacco and/or nicotine exposure. Additionally, smoking may have a significant negative effect on anesthesia and recovery from anesthesia, with coughing and possibly increased bleeding. Some complications that are more common in smokers include: bleeding, infection blood clots, pulmonary embolus, poor healing, increased bruising, major wound breakdown, failure of flap surgery, wound and chest infections, pneumonia, thrombosis, and heart and lung complications

__________Testing for nicotine is routinely performed on patients the day of surgery. Should you test positive for nicotine products, we reserve the right to cancel your procedure scheduled for that day. Refunds **will not** be given in this instance. If you should decide to reschedule your surgery, you will be charged 30% rescheduling fee.

Please indicate your current status as listed by initialing below:

__________I am a non-smoker and do not use tobacco or nicotine products. I understand the risks of second-hand smoke exposure can cause surgical complications and agree to avoid this type of exposure for six (6) weeks before **and** six (6) weeks after my surgery.

_________I am a smoker or I use tobacco or nicotine products. I understand the increased risk of surgical complications due to smoking or use of nicotine products and freely accept these risks and acknowledge that I have been counseled in detail by my surgeon or Sturm Cosmetic Surgery staff. I also understand the importance of refraining from smoking or the use of tobacco or nicotine products for at least six (6) weeks prior to my surgery and until my surgeon states it is safe to resume, if desired, when I am completely recovered from my procedure.

______________________________ ______________________________

Print Patient Name Date

Patient Signature	Date
Witness	Date

Financial Policy

POLICY NUMBER: 3.1
EFFECTIVE DATE: 10.2018
LAST REVISED DATE: 06.14.2023
NUMBER OF PAGES: 2

PURPOSE: To develop financial guidelines for patients and ensure that each patient understands these guidelines prior to scheduling a surgical procedure or treatment and paying a deposit.

Patients who visit Sturm Cosmetic Surgery for a consult will receive a copy of this Financial Policy. Upon receipt of the policy, each patient shall sign the Financial Policy Acknowledgment form, stating he or she understands and agrees to this policy, as amended or updated by Sturm Cosmetic Surgery.

- Ten percent (10%) of your surgical or treatment (this includes Halo, Broad Band Light (BBL), Skintyte, CO2 laser resurfacing, Tone, Sculptra to the body, Microneedling, V-tone, MorpheusV, FormaV, Accutite, Facetite, Femtite) proposal is due at the time you schedule a date. This is a **non-refundable** deposit that cannot be applied or used for any other future cosmetic procedures, products or services at SCS. This deposit **will however,** be applied to your remaining balance on your final treatment date. We will not schedule your procedure without receiving the 10% deposit.
- Your final balance, paid in full, is due three (3) weeks prior to your surgery or treatment date and is also **non-refundable**. If payment is not received three (3) weeks prior to your planned procedure, your surgery or treatment may be postponed or cancelled. If you would like to reschedule your procedure less than three (3) weeks prior to your date, a rescheduling fee will apply.
- For surgical revisions, fee is due **at the time** of scheduling per our Revision Policy.
- All patients must complete their pre-operative appointment and submit all necessary labs (including EKG, Mammogram, and medical clearance if requested by the surgeon) at least three (3) weeks prior to your surgery. It is your responsibility to notify our office if your contact information changes or needs to be updated. We will attempt to contact you three (3) times if you have not completed a preoperative appointment. If we are unable to reach you within 72 hours of our first attempt, then we reserve the right to cancel your surgery. If you wish to reschedule for a future date, a rescheduling fee may apply.
- Testing for nicotine and illicit drugs (including weight loss pills) are routinely performed on patients the day of surgery. Should you test positive, refuse to be tested or decide not to follow the instructions given to you by our clinical staff, then we reserve the right to cancel your procedure for that day. If you believe the test results are inaccurate, then you have the right to submit a blood test. If the blood test is negative, then you will not be charged a rescheduling fee. If your test is positive and your case has to be canceled the day of your surgery, a rescheduling fee will apply, **up to 30%** of your total fees.
- You must have an adult caregiver (minimum 18 years of age and aware of your surgical procedures) with you at all times for the first 24 hours after your surgery. Please contact our pre-

operative nurse if you have questions regarding your caregiver's expected responsibilities. If you do not have an appropriate caregiver with you at the time of your surgery, we may cancel your procedure and a rescheduling fee will apply, up to 30% of your total fees.

- At SCS, your safety is always our number one priority. The operating room fees in your surgery proposal are our best estimate of the time it will take to achieve your cosmetic goals. In order to avoid additional billing on any surgery involving liposuction, we estimate the operating room time based on your Body Mass Index (BMI) at the time of your consultation. Your BMI will fluctuate with any changes in weight. If your BMI has **increased by one or more points** on the day of the surgery, we may reschedule certain procedures, or you will be charged an additional $800 per point to cover the additional anesthesia and operating room fees associated with additional procedure time.
- Post-operative appointments are included into your cosmetic quotes.
- All skincare purchased is final sale and non-returnable.

Insurance

- At SCS, we **DO NOT** accept insurance for any case, treatment, or procedure. We **DO NOT employ a medical biller or coder at our office and therefore do not utilize or are familiar with the current ICD and CPT codes and standards. If you are wanting to submit a claim to your insurance provider, YOU, the patient, are solely responsible for doing this. You, the patient, are solely responsible for obtaining the ICD and CPT codes. Our office will provide you with your consultation note and follow up notes. You, the patient, are responsible for obtaining your operative note.**
- **You**, the patient, are responsible for the **full** amount of the cosmetic quote. This is due three weeks prior to your procedure.
- **SCS IS NOT** responsible for any portion or all of the procedure that your insurance does not cover. As mentioned, YOU, the patient, are responsible for the full balance of your cosmetic quote.
- If you are having a combined procedure (hernia, hysterectomy, etc) that is being performed at the hospital, you **will** receive a bill for surgical and anesthetic services not performed by Dr. Sturm. Services provided by another provider not affiliated with Sturm Cosmetic Surgery is NOT included in your surgical quote (hernia, hysterectomy, anesthesia etc). This charge for other services rendered at the hospital is NOT part of your Sturm Cosmetic Surgery quote and must be paid by YOU, the patient.

By signing below, you fully understand the financial agreement above.

We accept all major credit cards, cash, or check. We also offer patient financing through PatientFi, Care Credit, and Alphaeon Credit. Prescription medications (which are to be filled by the patient at their desired pharmacy) and lab work are not included in your financial proposal at Sturm Cosmetic Surgery. We have a full-time Financial Coordinator on staff to assist you with your financing choices and any questions you may have about this Financial Policy.

Patient signature___________________________________Date___________________________

Witness signature__________________________________Date___________________________

S T U R M
COSMETIC SURGERY
Beautifully You

CREDIT CARD INFORMATION

NAME: ____

CARD NUMBER: ____

CVV: ____

EXPIRATION DATE: ____

ZIP CODE: ____

PATIENT SIGNATURE: ______________________________ DATE: _____________

WITNESS SIGNATURE: ______________________________ DATE: ____________

**see Cancellation Policy for more details