Consultation ePacket

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Thank you for choosing **Allure Clinic** to accommodate your interests in cosmetic surgery.

Please review and submit the following information in order to move forward in scheduling or confirming your scheduling your surgical date and attaining the body transformation you desire.

Consultation ePacket Guide

Page 1 and 2 — **Financial Policy and Quote** — These pages will outline our Allure Clinic financial policy and also provide an itemized outline of your treatment plan.

Page 3 — **Medical Clearance Form** — Most doctors are used to providing this letter but below are the essential features of the letter we require. You may print the form below to take to your doctor. All patients over 55 years old are also required to have a recent EKG or Electrocardiogram submitted before they can be scheduled for their procedure(s).

Page 4 — **Patient Responsibility List and Pharmacy Information** — This page of the booklet asks you to submit your preferred pharmacy information and also outlines your responsibilities as the patient as you prepare for your surgery.

Thanks again! If you have any questions and/or comments, please send us an email to info@allureclinic.com or call us at (844) 725 5873.

Cosmetic Surgery Financial Policy

We would like to share the following policies with you, such that you understand your responsibility regarding the charges for services rendered.

Our medical team is committed to providing our patients with the best possible care. In order to achieve this, we need your assistance and understanding of the following policies.

Please review and sign this document to indicate that you understand the financial policies outlined below.

(a) The patient is financially responsible for the full cost of the procedure(s).

(b) The patient is required to pay a **minimum security deposit of five hundred dollars ($500) to schedule a tentative surgical date.** The patient will not be assigned their tentative procedure date until this deposit has been made.

(c) Security deposits are nonrefundable, unless the assigned physician is unable to perform the scheduled procedure. In such cases, the patient will receive a full refund for any services charged for at and/or by Allure Clinic.

(d) All outstanding balances for procedure(s) must be **paid in full at least ten (10) business day**s prior to the surgical procedure being performed.

(e) The prices and fees rendered as part of patients' treatment plan do not include the cost of blood work, prescription medication, compression garments or medical clearance (if necessary).

(f) Patients who cancel their procedures with less than fourteen (14) business days' notice will forfeit their deposit.

(g) Patients who cancel with less than fourteen (14) business days' notice due to medical reasons are required to bring in a notice (from a licensed medical practitioner) with an explanation for cancellation.

(h) Patients who reschedule their procedure(s) with less than ten (10) days before are required to pay a one-hundred dollar ($100) rescheduling fee.

(i) United Medical Credit is the only financing option that we make available to our patients. Patients must be approved for financing prior to scheduling their procedure. For patients who intend to provide payment via United Medical Credit, all fees are due 14 days prior to your scheduled procedure.

(j) For your convenience we accept cash, personal checks (up to ten days before your procedure), certified checks, most major credit cards, and United Medical Credit financing. You are able to pay in person in-office or by phone (844-725-5873). Payments collected directly at our facility will not accept United Medical Credit.

Patient Signature ✖_____

Cosmetic Surgery Procedure Quote

Patient Name:

Date of Consultation:

Date of eConsultation Packet Submission:

Tentative Surgical Date: Not Yet Assigned

Treatment Description	Pricing / Totals
	$
Post Operative Session	Included
Garment and/or Surgical Accessory Fees	
Pre-Operative Laboratory Fees	
Anesthesia Fees	$
Facility Fees	$
Procedure Subtotal	$
Total	$
Deposit	—
Balance	$

If you would like to submit your security deposit via credit card, please fill in the following information:

Name (as it appears on card) _____

Credit Card Number _____

Expiration Date ____/____ **CVV Code** _____ **Zip Code** _____

Amount ($) _____

Patient Signature ___✖ _____ **Date** _____

Medical Clearance Form

Dear **Doctor** (Please print) _____

Your **patient** _____ has expressed his/her interest in an elective cosmetic surgery procedure. If you have a history of medical illness, are over 55 years old and/ or are taking prescription medications for a medical illness we request that you see your primary care physician and obtain medical clearance to have elective plastic surgery.

Patient Name _____ **Date of Birth** (MM/DD/YYYY) _____

Height (in)_____ **Weight (lb)** _____

Date of Visit _____

History of Present Illness (HPI) _____

Medications _____

Allergies _____

Review of Symptoms _____

Physical Exam _____

Assessment/Plan: There are no foreseeable contradictions for this patient in undergoing elective plastic surgery.

Required Lab(s): The following tests must be completed and the results must be provided with the information specified above.

— Comprehensive Metabolic Panel (CMP)
— Hepatic Function Panel
— CBC with Differential Platelets
— PT/PTT INR
— HCG Quantitative
— HIV
— Hepatitis Panel

Based upon my observation / examination, it is my opinion that this patient:

_____ has full medical clearance to undergo elective cosmetic surgery

_____ may undergo elective cosmetic surgery **with the following restrictions**:
_____
_____

_____ **should not** undergo elective cosmetic surgery for the **following reasons**:
_____
_____

Physician Name (Printed) _____

Physician Signature _____ **Date** _____

Address or Stamp _____
_____
_____

Phone Number _____

Statement of Patient Responsibilities and Instructions

In recognition of our responsibility in rendering quality patient care, these rights and responsibilities are affirmed in the policies and procedures of the medical practice, Allure Clinic.

Please review the following list of patient responsibilities and verify that you have understood this information by signing the appropriate field at the bottom of the page.

Preferred Pharmacy Information

Pharmacy Name _____

Telephone Number _____

Address Street _____

City _____ State_____ Zip Code_____

Patient Responsibility Agreement

1. The patient must disclose all medications and medical conditions.
2. The patient must take prescribed antibiotics as directed.
3. The patient must stop all the consumption of all NSAIDS (e.g Advil, Aleve, Aspirin, Ibuprofen, Motrin, Naproxen) a minimum of (7) days prior to his/her procedure.
4. Must stop all vitamin supplements containing any Vitamin E, and/or any herbal products such as Melatonin, at least **(7)** days prior to procedure.
5. On day of procedure, the patient may consume a light breakfast.
6. On the day of your procedure, you are advised to wear loose clothing.
7. The patient is advised to purchase a post operative compression garment. We have several options available that can be purchased on site.
8. The patient accepts full responsibility for any undisclosed medical conditions, medications, allergies and/or recreational drug use.

Patient Signature *x*_____