[COMPANY NAME] &
PATIENT CONSENT AND AGREEMENT

[COMPANY NAME] (referred to herein as "Practice," "we," "us," and/or "our") maintains the policies below. By signing this Patient Consent and Agreement, I agree to receive the services described below from Practice and its employed, contracted, and affiliated healthcare and other providers in accordance with the terms set forth below.

1. **Services**. I agree that the services that I receive from Practice will consist of aesthetic treatments performed by healthcare and other providers who are, as applicable and appropriate, licensed in Michigan ("Services"). I acknowledge that the Practice's providers are not performing a complete physical examination. I agree that no one at the Practice is "on-call" and that I am advised to obtain and maintain a primary care physician for my overall healthcare and on-call needs. I agree to assume complete and full responsibility to take appropriate action with regard to the recommendations provided by Practice's providers.

   _____ (initial) I acknowledge that I have carefully read the information above and that I agree to it.

2. **Payment for Services**. I agree that I am financially responsible for and will pay all incurred charges for all Services provided by Practice and its employees, contractors and providers. Except as otherwise stated below, I agree that Practice does not participate in any insurance networks and that Services are not believed to be covered by insurance networks or federal or state third-party payors (e.g., Medicare, Medicaid, etc.). I, therefore, agree to make all payments in cash or other forms of accepted payment directly to Practice via Practice's then-current third-party payment platform. I agree that I will not seek reimbursement from Medicare or Medicaid for Services rendered by Practice. I agree that Practice will not seek reimbursement from any federal, state or third-party payor. It is my responsibility to understand my insurance benefits including, without limitation, my copays, coverage and deductibles, and any required referrals should I seek to obtain reimbursement from third-party payors myself.

   Practice maintains a standard fee schedule, subject to change from time to time. All Services shall be paid pursuant to the Practice's then-current fee schedule in accordance with Practice's then-current payment policies, which currently require payment prior to or at the time of Service. Payments not received after 30 days of the statement date will be assessed a late fee of $___. This fee will accrue at a rate of $___ per 30 days late. I understand that Practice has the right to forward unpaid accounts to a collections agency and I agree to bear and reimburse Practice for all costs including, without limitation, filing fees, service fees, and attorney fees) associated with Practice's collection efforts on my account.

   _____ (initial) I acknowledge that I have carefully read the information above and that I agree to it.

3. **Appointments**. I agree to contact Practice immediately if I expect my appointment to be delayed or if I am unable to keep my appointment in light of unforeseen circumstances. In general, we request at least 24 hours' advanced notice of any cancellations. In the event of my late arrival or a missed or cancelled appointment without at least 24-hour notice provided, I agree that my appointment may need to be rescheduled and that I may be required to pay a $_____.00 cancellation fee.

   _____ (initial) I acknowledge that I have carefully read the information above and that I agree to it.

4. **Email and Text Communications**. Unencrypted emails and text messages are not recognized as secure communication forms and my agreement to communicate via text or unencrypted emails on a non-confidential basis at my risk. I will not send any information I consider private to Practice by email or text. Practice is not responsible for the security of any information transmitted using any phone number or email address I provide. If I consent to receive texts or emails from Practice or any of its employees or contractors, I acknowledge that I am aware of the above-mentioned risks of using text and/or email, I accept and agree to such risks and I agree to receive text and/or email communications from Practice and its employees and contractors.

   _____ (initial) I acknowledge that I have carefully read the information above and that I agree to it and that I consent to receiving communications from Practice by unencrypted emails and appointment reminders via text messages.

5. **Emergency Services**. I hereby agree that Practice will not be liable for any failure to provide, or delay in providing, services to me in the event that Practice and its providers are assisting another patient(s) in an emergency or in the event of other circumstances beyond the reasonable control of Practice. **In the event of an emergency, or a situation in which I could reasonably expect an emergency to arise, I agree to call 911 or visit the nearest emergency room and follow the directions of emergency personnel.**

   _____ (initial) I acknowledge that I have carefully read the information above and that I agree to it.

6. **Release and Indemnification.** I acknowledge that Practice is not performing physical examination, medical and test interpretation services, or any healthcare services outside of Services and Practice is not liable for civil damages as a result of acts or omissions in performing Services. I hereby expressly, fully and forever agree to release, waive, indemnify, discharge, and hold harmless Practice, its owners, managers, investors, directors, officers, representatives, affiliates, employees, providers, agents, and contractors (collectively, the "Indemnified Parties") from, and covenant not to sue any Indemnified Parties for, any and all liabilities, claims, losses, judgments, damages, costs, demands or causes of action, including attorney fees, that I or any of my heirs, assigns, executors, personal and legal representatives, guardians, parents, durable powers of attorney, and next of kin may have at any time for any reason resulting from or related, indirectly or directly, in whole or in part, to Services rendered by Practice regardless of any sole, concurrent or

contributory negligence, acts, omissions or fault of Indemnified Parties. This Section shall survive termination or expiration of this Patient Consent and Agreement.

_____ (initial) I acknowledge that I have carefully read the information above and that I agree to it.

7. **General Terms.** This Patient Consent and Agreement shall be governed by the laws of the State of Michigan without regard to its conflict of laws provisions. All disputes arising out of, or related to, this Patient Consent and Agreement shall be submitted to binding arbitration in Michigan nearest to the city where Practice is located, pursuant to the rules of the American Arbitration Association with one (1) arbitrator to be selected by mutual agreement of both parties. If the parties cannot agree on an arbitrator within thirty (30) days of a party's request for arbitration, then the American Arbitration Association shall select an arbitrator from the National Panel of Arbitrators. I hereby waive my right to trial in any court, however, judgment on the award rendered by the arbitrator may be entered in any court of competent jurisdiction in or nearest to the city where Practice is located in Michigan. All costs and expenses of arbitration shall be awarded to the prevailing party, except that each party shall pay for its own legal fees and one-half of the fees and costs of the arbitrator.

My signature below evidences my voluntary agreement to receive this treatment from the Practice, and that I am the patient or am authorized to act on behalf of the patient to sign this consent form. By signing below, I agree that I have read, understand, and agree to all of the statements contained in this consent form. My signature below further evidence that I have been informed about the treatment and the purpose, procedures, possible benefits and risks to my satisfaction and I accept them and consent to the treatment. I understand that the provision of treatments is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results or outcome of the treatment. I agree that I have been given an opportunity to ask questions before I sign and my questions have been answered to my satisfaction, and I have been told that I can ask other questions at any time. I understand that my agreement is effective on the date signed below and that I may revoke my agreement in writing. My revocation will not be effective for actions already taken by the Practice or that are in progress and will only be prospectively effective.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

(If applicable) Patient Parent/Guardian Signature: _____ Date: _____

Patient's Parent/Guardian Printed Name: _____