This AGREEMENT for services ("Agreement") is made as of the 04/18/2024, by and among (the "Patient") and Stillwater Plastic Surgery, P.A. d/b/a Capizzi, MD ("Capizzi"). The Patient and Capizzi are collectively referred to, when applicable, as the "Parties."

In consideration of the mutual promises and covenants contained in this Agreement and other good and valuable consideration, the receipt and sufficiency of which is acknowledged, the undersigned Parties agree as follows:

1. Non-Participating Insurance Acknowledgement

Capizzi, MD does not participate with any insurance companies. Capizzi, MD reserves the right not to submit insurance claims for the services rendered and not to facilitate the insurance claim process (including providing insurance codes). If I choose to apply for insurance reimbursement through a non-contracted insurance company, I may be responsible for submitting claims to my insurance company. I will be provided all operative notes from Capizzi, MD Cosmetic Surgery & Med Spa to submit these claims. If my medical records are required, I understand there will be a $30 administrative fee for compiling, reviewing, and release of the records.

2. Financial & Scheduling Policies for Non-Surgical Treatments

Booking & Paying For Your Treatments

Skincare and injectable treatments do not require prepayment to book an appointment time. Payment in full is due at the time of service. If payment is not remitted during an appointment, practice retains the right to charge the card on file for the outstanding balance and by signing this agreement, patient authorizes that charge.

When booking any of the following non-surgical treatments, payment in full will be required prior to scheduling:

- miraDry Sweat Reduction
- diVa Laser Vaginal Therapy
- CoolSculpting
- morpheus8
- Laser Treatments: HALO & MicroLaser Peels
- Sculptra

We do offer CareCredit financing options for any balances over $1000 please see details below

Cancelling Treatments

If you need to cancel your treatment, please let us know as soon as possible. Cancellations requested less than 72 hours in advance of your appointment time are subject to a cancellation fee of 50% of the scheduled treatment total. If more than 72 hours in advance, this appointment is subject to a cancellation fee of $1000.

Rescheduling Treatments

Non-surgical treatments may be rescheduled up to one time, a minimum of one calendar week in advance, with no penalty. If you reschedule you treatment for a second time or request to reschedule less than one calendar week in advance, a rescheduling fee of $250 will apply.

No Call/No Shows

If you fail to show up for your appointment and do not call prior to the appointment time, you will be charged for 100% of your scheduled treatment. Please understand that we value your time and we ask the same respect in return.

Treatment Packages & Pre-paid Services

All treatment packages and pre-paid services expire 2 years after date of purchase.

Refunds

All sales are final, and refund requests may be sent to Capizzi MD at frontdesk@capizzimd.com but are not guaranteed and are at discretion of the business to approve based on individual circumstance.

3. Financial & Scheduling Policies for Cosmetic Surgery

Cosmetic surgery procedures are not covered under health insurance. Patients are responsible for full payment of cosmetic surgery. Once your surgery has been scheduled on a cosmetic basis, our office will not assist any patient in attempting to establish medical necessity for the surgery.

Booking Your Surgery

To reserve a surgical time, a $2000 non-refundable booking fee is due before we are able to proceed. This booking fee covers the costs of booking and scheduling the surgery and will go towards your payment for surgery. As such, it cannot be applied or used for any future procedures, products, or services. We cannot schedule your surgical procedure without receiving the $2000 non-refundable deposit.

We will accept cash, cashier/certified check, EFT, financing through CareCredit with a administrative fee of $300, or major credit card with a 3% service fee. We do not accept personal checks.

Paying For Surgery

Surgery scheduling requires careful planning and coordination between our office, the operating room staff, and your anesthesia provider, if applicable. In addition, special surgical and medical supplies, medicines, and instruments are ordered ahead of time for each case, and instruments are prepared and sterilized for each individual procedure. The operating room and your anesthesia provider are reserved for your specific surgery. Therefore, please understand the importance of our Cancellation & Rescheduling Policy, outlined below.

The entire balance of your financial responsibility is due at your pre-operative appointment, a minimum of 14 calendar days before your surgery date. If payment is not received 14 calendar days prior to surgery, your surgery date will be postponed or cancelled and rescheduling fees applied per the policy below.

Cancelling Surgery

When scheduling your surgery, your booking fee reserves a specific surgery date. Cancellation of your surgical procedure for any reason will incur the following fees :

- Cancellations made more than 14 days prior to your surgery date will result in the loss of the $2000 non-refundable booking fee.
- Cancellations made less than 14 days prior to your surgery date will result in the loss of your entire surgery payment, due to loss of facility, scheduling, and staffing costs.

Rescheduling Surgery

Surgeries may be rescheduled up to one (1) time, a minimum of one (1) month in advance of either date with no penalty. If you reschedule your surgery for a second time, or within a month of your surgery date, a rescheduling fee of $1000 will apply.

**If your surgery must be rescheduled due to patient error, the following fees will apply:

· Error resulting in adjusting same-day surgery time = $500

· Error resulting in rescheduling for a new surgery day = $1000

Common errors include, but are not limited to: Arriving late, eating/drinking ANYTHING after midnight the night before, non-disclosure of medications, failing to arrange appropriate post-operative care, etc.**

Facility & Anesthesia Fees

In the event that my surgical time is extended, each additional half hour of surgical time may result in the increase of approximately $1000 in facility and anesthesia fees. In the case of an increase in surgical time, the procedure fees would not change.

Included Follow-up Appointments

Depending on your procedure, we include a number of followup appointments with your procedure. Please see below for a complete list of included appointments, any additional followup appointments incur a fee.

1. Minor procedure (skin tag or lesion removal): 10 day followup
2. Local anesthesia (labiaplasty, scar revision, or explant): 1 week, 1 month, and 3 month followups
3. Surgical procedures: All followups within 1 year of the procedure are included

Complications and Unsatisfactory Results

I understand that should post-operative complications arise necessitating additional surgery, anesthesia, laboratory tests, etc. that I am responsible for any and all charges incurred. I understand that unsatisfactory results may occur and that I may be disappointed with the results of my surgery. Although good results are expected, there is no guarantee or warranty, expressed or implied, of the results that may be obtained. Additional surgery may be required to improve results and the financial responsibility of the procedure will rest with the patient. This would include, but not be limited to risks such as asymmetry, unsatisfactory or visible scars, unacceptable visible deformities, poor healing, and wound disruption. It may not be possible to correct or improve the surgical results. In some situations, it may not be possible to achieve optimal results with a single surgical procedure.

Pathology, Medications, and Additional Costs

I understand that additional charges may sometimes occur should unforeseen circumstances arise or if laboratory testing is performed. The costs of medications and lab work are additional and NOT included in the procedure fees paid to Capizzi, MD Cosmetic Surgery & Skincare.

4. CareCredit Patient Financing Program

We offer patient financing through CareCredit for any procedures or treatments totaling $1000 or more. We are happy to provide you with more information regarding the program. When using CareCredit, please be aware that a $300 Administrative Fee will be due in addition to the balance.

5. DEFAULT / PAYMENT / REASONABLE ATTORNEYS' FEES. Upon default, Capizzi, or its assignee, in its sole discretion, may employ an attorney or third party to enforce Capizzi's rights and remedies, and the Patient hereby agrees to pay Capizzi's reasonable attorneys' fees plus all other reasonable expenses incurred by Capizzi in exercising the rights and remedies provided upon default. Moreover, in the event of default, Patient hereby agrees and acknowledges that all sums due and owing shall bear interest at the rate of eight percent (8%) per annum.

6. TERMINATION: It is the policy of Capizzi to maintain cooperative and trusting physician-patient relationship with the Patient. When such a physician-patient relationship is no longer proceeding in a mutually productive manner, it is the policy of Capizzi to terminate the physician-patient relationship within the bounds of applicable state and federal laws, rules, and regulations, and the American Medical Association guidelines. Said policy allows the Patient to develop the type of trusting relationship with another physician that is essential to successful continued care and treatment for the Patient.

7. NON-DISPARAGEMENT. The Patient shall not, and agrees not to, at any time regardless of whether the physician-patient relationship is terminated, take any action or to make any statement, written, digital or oral, that disparages Capizzi or any of its respective directors, officers, agents, employees or contractors. Patient further agrees not to take any action that is intended to, or that does in fact, damage the business or reputation of Capizzi or any other related entity, or the personal or business reputations of any of its respective directors, officers, agents, employees or contractors, or that interferes with, impairs or disrupts the normal operations of Capizzi. Nothing in this Section 13 or any other part of this Agreement, is intended to prevent the Parties from testifying truthfully under subpoena or as may otherwise be required by law.

8. USE OF LIKENESS: Patient hereby acknowledges and grants to Capizzi and its related, subsidiary and affiliated companies, successors and assigns, and to such other persons as Capizzi may designate or give permission to from time to time (collectively, the "Licensees"), the absolute, irrevocable right and permission to use, in any manner, throughout the world, in perpetuity, my name, portrait, likeness, testimonials and statements (including but not limited to photographs, video, film and/or other recordings of me), either alone or accompanied by other material, such as still images or footage, in any media and formats whether now known or later developed, for any purpose relating to developing and promoting Capizzi's business, its products and/or services. I agree that I will not hold or seek to hold Capizzi and/or the Licensees responsible for any liability resulting from the use of my name, portrait, likeness, photograph and/or footage in accordance with the terms of this Agreement, including, but not limited to what might be deemed as to be a misrepresentation of me, my character or my person due to distortion, optical illusion or faulty reproduction that may occur in the finished product. I acknowledge the fact that Capizzi and the Licensees are not obligated to make any use of my name, portrait, likeness, biographical information, still images and/or footage. The foregoing includes the permission by the Patient granting Capizzi and the Licensees to use the Patient's name, portrait, likeness, testimonials and statements (including but not limited to photographs, video, film and/or other recordings of me) which allows any form of social media utilized by Capizzi and the Licensees including, but not limited to, Facebook, Instagram, Youtube, Twitter, Snapchat, and the like, whether now known or later developed.

9. WAIVER. Patient agrees that no waiver by Capizzi of any breach, default or violation of any provision of this Agreement shall constitute a waiver of any subsequent breach, default or violation of the same or other provision of this Agreement. The mere delay in enforcement of a right shall not be a waiver of a default. No waiver shall be effective unless in writing signed by the party to be charged.

10. ASSIGNMENT. Patient acknowledges that Capizzi may freely assign its rights set forth herein and that Patient's obligations shall inure to the benefit of Capizzi, its successors, and assigns successors, assigns, affiliates, agents, insurers, employees, legal representatives and any other persons or entities acting on their behalf or claiming through or under them or any of them, and shall inure to the benefit of all the Parties, as well as each of their respective heirs, predecessors, successors, assigns, affiliates, agents, insurers, employees, legal representatives and any other persons or entities acting on their behalf or claiming through or under them or any of them.

11. GOVERNING LAW AND VENUE. This Agreement shall be deemed to be a contract made under, and for all purposes shall be governed by and construed in accordance with the laws of the State of North Carolina. Any legal suit, action or proceeding arising out of or related to this Agreement or the matters contemplated hereunder shall be instituted exclusively in the federal courts of the United States or the courts of the State of North Carolina in each case located in the city of Charlotte and County of Mecklenburg, and each Party irrevocably submits to the exclusive jurisdiction of such courts in any such suit, action or proceeding and waives any objection based on improper venue or forum non conveniens.

12. COUNTERPARTS. This Agreement may be executed in duplicate counterparts, each of which shall be deemed an original and all of which shall constitute but one and the same instrument.

13. SEVERABILITY. The Parties agree that if any term of this Agreement is deemed to be invalid for any reason, the remaining terms and provisions shall retain their full force and effect.

14. ENTIRE AGREEMENT. No promise or agreement other than those recited above has been made as consideration for the releases and discharges affected by this Agreement, and the Parties enter into this Agreement for the sole consideration recited herein. This Agreement constitutes the entire agreement and understanding of the Parties and supersedes all prior proposals, negotiations, understandings, representations and agreements relating to such subject matter.

15. COSTS AND FEES. The Parties agree that they shall pay their own costs and attorneys' fees associated with the negotiation and execution of this Agreement.

16. AUTHORITY. The Parties represent and warrant that he/she/it is fully authorized to execute this Agreement on behalf of the respective party.

17. HEADINGS. The headings in this Agreement are inserted for convenience only and are not to be considered in construction of the provisions.

18. ACKNOWLEDGEMENT. Patient hereby acknowledges that he/she has discussed the Financial and Scheduling Policy provided in this Agreement and fully understands the terms and conditions as well as the Patient's financial obligations provided herein.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be duly executed and delivered on the date first written above.

CAPIZZI, MD
COSMETIC SURGERY & MED SPA

By signing below, I, acknowledge the above Office Policies and accept the terms of this agreement.

Patient's Full Name

Date

04/18/2024

Signature *

Notice of HIPAA Privacy Policies

THIS NOTICE PROVIDES INFORMATION ON HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED. THIS NOTICE ALSO DESCRIBES HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

Each time you visit a healthcare provider a record of your visit is created. This record typically contains symptoms, examinations, tests and test results, diagnoses, treatment options and plan of care or future treatment. It also contains related billing information. This notice applies to all of the medical records generated by our clinic. If you go to another facility, i.e., hospital or other practitioner, their policies or notices regarding use and disclosure of your health information may be different.

Our Responsibilities:

We are required by law to protect the privacy of your health information and provide you with a description of our privacy practices.

Uses and Disclosures (How we may use and/or disclose health information about you):

For Treatment: We may use your health information to provide you services or treatment. We may disclose this information to other healthcare providers who are involved in the coordination of your care. This includes, doctors, nurses, medical technicians, medical students or other facility personnel who are involved in your care.

If we are not your primary care provider, we may also provide your primary care provider or subsequent healthcare providers with copies of various records that can assist them in your treatment once you leave our care.

For Payment: We may use and disclose health information about you to bill and collect payment from your insurance company or third party payer.

For Health Care Operations: Our care coordination team may use your health information to assess the outcome and care of your case and those that are similar. Results of this outcome could help to continually improve quality of care for other patients that we treat.

We may also use and disclose your health information for the following:

1. For business associates that we have contracts with such as medical billing and coding companies.
2. For medical appointment reminders to you
3. For communicating satisfaction surveys that pertain to our services
4. For fundraising efforts unless you choose not to be involved in such communications
5. For communication with you regarding alternative treatments
6. For communication with you regarding other health related services
7. For training purposes for newly hired healthcare professionals in our practice

Appointment reminders and billing/collection issues may be communicated via discreet phone messages or secure email.

Business Associates: Services provided by outside organizations in which we have contracted. Examples would include, but are not limited to, medical billing and coding companies, laboratory testing and diagnostic imaging companies and pathology. Business associates are required by federal law to safeguard your health information.

Affiliated Covered Entity: PHI (protected health information) will be made available to medical staff in affiliated clinics or facilities when necessary to carry out treatment, payment and operations.

As required by Law, our clinic may also use and disclose your PHI to the following, including but not limited to:

- Public Health or Legal Entities who are in charge of controlling/preventing disease, disability or injury.
- Workers Compensation Carriers
- Food and Drug Administration
- Homeland Security
- Correctional Facilities
- Agencies for Organ/ Tissue Donation
- Military Authorities
- Law Enforcement Agencies/Court Proceedings with subpoena or required by law.

Your Rights

Even though your medical record is physical property of the clinic who documented it, you have the right to:

Inspect and make copies: You can inspect and request copies of your medical record. This however, does not include mental health related notes. Limited circumstances will allow us to deny your request to inspect and copy your medical records. If access is denied, your denial can be reviewed by another licensed healthcare professional at your request. This request must be presented to our clinic in writing. We will comply with the decision of the review.

Amendment: You may ask to amend information that you feel is incorrect or incomplete in your medical record. This request must be presented in writing to our clinic.

Disclosure Log: You may ask for a record of disclosures. This is a list that we are responsible for keeping that tracks disclosures of your health information where authorization is not required.

Limitation/Restriction Requests: You may ask that your health information be limited or restricted for disclosure for treatment, payment or healthcare operations. Requests must be presented to our clinic in writing and must be very specific. Example: You may ask that we not use information regarding a cosmetic surgery that you had.

We are required to honor your request only if:

- Except as required by law, the disclosure is to your health insurance and related to health care operations or payment.
- Your healthcare information pertains exclusively to services which you paid in full.

Any other requests, we are not required to concur.

Confidential Communication Requests: You may request that we communicate with you regarding medical affairs at a particular location or manner. Example: You may request that we contact your cell phone instead of your place of business. Reasonable requests for confidential communications will be honored. Requests for confidential communication must be presented to our clinic in writing. *Notice-We reserve the right to contact you by other means necessary when failure to obtain a response is an issue.

Notice Copy: You may ask for a copy of this notice. This can be requested at any time. You are entitled to a paper copy even if electronic copy is the standard.

Notice Revisions: We will revise this notice as mandated by law. You will be asked to sign an updated copy of this notice on an annual basis.

By signing below, I, , acknowledge that I have reviewed the above HIPAA Policy and accept the terms.

Patient's Full Name

Date

04/18/2024

Signature *