7611 Forest Ave · Suite 210
Richmond, VA 23229
(804) 290-0909
Fax (804) 290-0333
www.DrSundin.com

VIRGINIA INSTITUTE of PLASTIC SURGERY

MODERN BODY CONTOURING AND LASER CENTER

1500 Cornerside Blvd · Suite 400
Vienna, VA 22182
(703) 740-8333
Fax (703) 740-8775
www.MyModernBody.com

Burton M. Sundin, M.D. / Reps B. Sundin, M.D

Date: _____

Name (Last, First, MI): _____

Address: _____

Zip, City, State: _____

Home#: _____ **Work#:** _____ **Cell#:** _____

Email address: _____

Patient Status: □ 1-Married □ 2–Single □ 3-Separated □ 4-Divorced □ 5-Widowed □ 6-Other

Birthdate: _____ **Sex:** _____ **Social Security#:** _____

Referred by: _____ **Primary Care Dr:** _____

Do you have a living will? No Yes

Emergency Contact: _____ **Phone#:** _____

***** GUARANTOR INFORMATION/SECONDARY ADDRESS:**

Name: _____ **Phone#:** _____

Address: _____ **SS #:** _____

Empl Status: □ 1-Empl FT □ 2- Empl PT □ 3-Retired □ 4-Not Empl □ 5-Student FT □ 6-Student PT

Employer's name: _____ **Phone#:** _____

Address: _____

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services. I also authorize the physician to release any information required to process this claim and in the course of my exam and treatment.

SIGNED: _____ **DATE:** _____

WOULD YOU LIKE TO RECEIVE EMAILS ON OUR UPCOMING EVENTS AND SPECIALS? YES/NO

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DATE: _____

NAME: _____ **AGE:** _____

DATE OF BIRTH: _____ **SEX:** _____ **HEIGHT:** _____ **WEIGHT:** _____

WHO REFERRED YOU TO OUR PRACTICE: _____

REASON FOR CONSULTATION:

_____

_____

ALLERGIES: _____

DO YOU SMOKE?	**Y**	**N**	**If yes, frequency:** _____
DO YOU DRINK ALCOHOL?	**Y**	**N**	**If yes, frequency:** _____
DO YOU USE RECREATIONAL DRUGS?	**Y**	**N**	
DO YOU TAKE BLOOD THINNERS?	**Y**	**N**	
DO YOU OR HAVE YOU EVER TAKEN STERIODS?	**Y**	**N**	

CURRENT MEDICATIONS:

_____

_____

_____

MEDICAL PROBLEMS:

_____

_____

_____

PREVIOUS SURGERIES:

_____

_____

_____

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MEDICAL HISTOR/ REVIEW OF SYSTEMS: **HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING CONDITIONS?**

HEART DISEASE (including Heart Attack, Congestive Heart Failure, Congenital Heart Defect of Disorder)	Y	N	**BLOOD CLOT (DVT)**	Y	N	**ASTHMA**	Y	N
HIGH BLOOD PRESSURE	Y	N	**PULMONARY EMBOLISM**	Y	N	**LUNG DISEASE**	Y	N
STROKE	Y	N	**ANEMIA**	Y	N	**GLAUCOMA**	Y	N
KIDNEY DISEASE	Y	N	**MENTAL HEALTH PROBLEMS**	Y	N	**CANCER**	Y	N
HEPATITIS	Y	N				**KELOIDS**	Y	N
DIABETES	Y	N	**HIV/AIDS**	Y	N	**EXCESSIVE SCARRING**	Y	N
			ANY OTHER MEDICAL PROBLEMS	Y	N	**EXCESSIVE BRUISING**	Y	N
						BLEEDING/CLOTTING DISORDER	Y	N

PLEASE EXPLAIN ANY "YES" ANSWERS ABOVE:

_____

_____

PERSONAL PHYSICIAN: _____ LAST MEDICAL EXAM: _____

HAVE YOU OR ANY OTHER RELATIVE HAD PROBLEMS WITH ANESTHESIA? Y N

HAVE YOU EVER HAD CHEMOTHERAPY? Y N

HAVE YOU EVER HAD RADIATON TREATMENT? Y N

IF YES, WHAT PART OF YOUR BODY? _____

Number of term pregnancies: _____ History of weight loss? Y N amount of weight lost:_____ Maximum Weight_____

Do you have or have you ever had problems with:

General:			**Eyes:**			**Musculoskeletal:**		
Fever	Y	N	Irritation of the eyes/eyelids	Y	N	Joint Pain	Y	N
Weight Loss/Gain	Y	N	Blurred Vision	Y	N	Back Pain	Y	N
Endocrine:			**Gastrointestinal:**			**Skin:**		
Excess Thirst	Y	N	Diarrhea	Y	N	Itchiness	Y	N
Insomnia	Y	N	Constipation	Y	N	Skin Allergies	Y	N
			Eating Problems	Y	N	Cold Sores	Y	N
Lungs/Respiratory:			**Lymph/Hematology:**			**Cardiovascular:**		
Shortness of breath	Y	N	Bleeding	Y	N	Chest Pains	Y	N
			Sweating	Y	N	Palpitations	Y	N
						Ankle Swelling	Y	N
Psychiatric:			**Allergy/Immunology:**			**Urinary:**		
Depression	Y	N	Dust	Y	N	Difficulty Urinating	Y	N
Suicidal Thoughts	Y	N	Ragweed	Y	N	Frequency	Y	N
Anxiety	Y	N	Molds	Y	N	Burning	Y	N
			Other: _____					
ENT:			**Pregnancy Issues:**			**Neurological:**		
Nose Bleeds	Y	N	Currently Pregnant	Y	N	Headaches	Y	N
Ringing in Ears	Y	N	If yes, due date: _____			Numbness	Y	N
Problems Swallowing	Y	N	Currently Breast Feeding	Y	N	Seizures	Y	N
			Planning Pregnancy	Y	N			
			Miscarriage	Y	N			

Completed by: □ Patient □ Nurse/Medical Assistant □ MD

I hereby certify that the information provided above is true and accurate to the best of my knowledge. I recognize that the information provided above will be used in my medical care and has direct implications with regard to care including but not limited to selection of treatment and potential outcomes or complications.

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Printed name: _____ *Signature:* _____

CONSENT TO TREATMENT AND RESPONSIBLITY AGREEMENT

Please read each section carefully. You may request a copy of this form for you own records.

Patient name: _____

I, the undersigned, do hereby request and consent to an evaluation and treatment by Dr. Burton M. Sundin, Dr. Reps B. Sundin, and/or tbe designated staff of Virginia Institute of Plastic Surgery/MBody. I wish to rely on Dr. Burton M. Sundin and/or Dr. Reps B. Sundin to exercise judgement for my best interest me or that of my dependent, the above-named patient, during the course of treatment. I will inform Dr. Burton M. Sundin and/or Dr. Reps B. Sundin or his assistant, who is treating me or my dependent of any sensitive areas or adverse conditions that I or my dependent may have had prior to, during, or after treatment. I intend this consent to cover the entire course of treatment.

I consent to the taking of photography by Dr. Burton M. Sundin and/or Dr. Reps B. Sundin or his designee of me or parts of my body in connection with the plastic surgery procedure(s) or non-surgical procedures to be performed by Dr. Burton M. Sundin and/or Dr. Reps B. Sundin or their employees.

I clearly understand and agree that all services rendered to me or to my dependent, the above-named patient, may be charged directly to me and that I am personally responsible for full payment. I understand that even if I suspend or terminate treatment, any fees for professional services rendered to me or to my dependent up to the point of termination will be immediately due and payable.

I acknowledge that Dr. Burton M. Sundin and/or Dr. Reps B. Sundin and Virginia Institute of Plastic Surgery may not participate directly with my insurance carrier and that I am responsible for any outstanding fees for services provided to me or to my dependent, the above-named patient, by Dr. Burton M. Sundin and/or Dr. Reps B. Sundin and/or Virginia Institute of Plastic Surgery that are not reimbursed through insurance or other third party payers; this includes all co-payments, deductibles, and out of pocket costs. I understand that a potentially refundable deposit to cover fees for uncovered services may be required at the time of service or follow up. I acknowledge that a 1.5% per month interest charge may be added to any balance unpaid after 90 days of aging. I further acknowledge that I will be held responsible for any and all expenses incurred by Dr. Burton M. Sundin and/or Dr. Reps B. Sundin and/or Virginia Institute of Plastic Surgery for any fee collection process, including a 30% attorney fee on any balance referred to an attorney for collection as a result from my delay in payment for services rendered by Dr. Burton M. Sundin and/or Dr. Reps B. Sundin and/or Virginia Institute of Plastic Surgery.

I agree that, I will not audio record, video record or take unauthorized photographs of the office, staff, consultation process or treatment process during my visits at Virginia Institute of Plastic Surgery/MBODY, or at facilities where they operate or see patients. Video or Audio recording is strictly prohibited without the explicit permission of Dr. Sundin

With regard to cosmetic or self-pay procedures: I understand that hospital fees, fees for laboratory tests or studies, cost of medications, anesthesia fees, and operating room fees related to cosmetic or self-pay procedures will likely not be covered by my insurance carrier. I understand that I will be responsible for all facility and anesthesia fees incurred for subsequent revision and/or emergency procedures performed on me or my dependent, the above named patient, as well as necessary supplies including but not limited to implants, unless otherwise specified by Dr. Burton M. Sundin, Dr. Reps B. Sundin. I will also be financially responsible for any studies, Pathology, laboratory tests, medications, anesthesia and hospital fees related to cosmetic procedures or self-pay procedures or complications thereof. Any surgeon's fee that may be incurred for subsequent revision and/or emergency procedures will be addressed on a case by case basis. If any fees are waived, refunded, and/or paid by the physician or office; this action does not constitute an admission of guilt, malpractice, or wrongdoing.

I authorize Virginia Institute of Plastic Surgery to submit all precertifications and claims directly to the insurers on my behalf. I hereby authorize the release of my medical records and other information necessary to process insurance claims. I understand and agree that any and all monies/funds received from insurance companies and/or other third-party payers as reimbursement for services rendered to me or to my dependent, the above-named patient, by Dr. Burton M. Sundin and/or Dr. Reps B. Sundin and Virginia Institute of Plastic Surgery. Any other arrangements that may involve insurance billing, reimbursement, payment plan, or payment deferral, must be made in writing with the office manager and/or Dr. Burton M. Sundin and/or Dr. Reps B. Sundin. Verbal agreements are not acceptable.

Relationship to patient: _____

Signature: _____ Date _____

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CANCELLATION POLICY FOR COSMETIC OR SELF-PAY PROCEDURE

By signing this document, I agree to the following cancellation policy of Virginia Institute of Plastic Surgery, PC. (abbreviated in this document as "VIPS")

I. To secure a cosmetic of self-pay procedure or surgery date, a $1000 nonrefundable deposit per procedure is required.

II. All fees due to Dr. Burton or Dr. Reps Sundin are due 30 days prior to the surgery or procedure date and are nonrefundable.

III. All fees to Virginia Institute of Plastic Surgery, PC are due and nonrefundable after the calendar date 30 days prior to the date of surgery. There will be no refunds given for procedures cancelled after the calendar date 30 days prior to the day of surgery.

IV. If a surgery or procedure is booked within a period less than or equal to 14 days prior to the surgery or procedure date, all fees are immediately nonrefundable.

V. In the event of cancellation, nonrefundable fees paid to Virginia Institute of Plastic Surgery, PC may be utilized for future services or products. These credits will expire 365 days past the initial payment date, unless other arrangements are agreed upon by the patient and Virginia institute of Plastic Surgery, PC in writing. These Credits are non-transferable and may only be utilized by the patient personally.

VI. Cancellation or rescheduling of a surgery within 30 days of the surgery date are subject to a rescheduling fee of 25% of the total cost of the surgery. Additional cancellations or rescheduling will be subject to an additional 25% fee.

VII. Cancellation secondary to: acts of God, fire, electrical outage, weather events, mandatory shutdown by the government, disease outbreak, epidemic, pandemics, quarantine, acts of terrorism or war, hospital or surgery center closure, cancellation by the hospital or surgery center, office building closure, death or illness of the physician, death or illness of the patient, delay in transportation of the physician or patient will NOT result in any refunds.

VIII. Dr. Sundin will make a reasonable attempt to reschedule the procedure or surgery. A second cancellation of a procedure or surgery by the patient for whatever reason will result in no further scheduling of that procedure and forfeit of all funds paid to Virginia Institute of Plastic Surgery, PC.

IX. I further acknowledge that I will be held responsible for any and all expenses incurred by Dr. Burton M. Sundin or Dr. Reps B. Sundin and/or Virginia Institute of Plastic surgery for any fee collection process, including a 30% attorney fee on any balance referred to an attorney for collection as a result from my delay in payment for services rendered by Dr. Burton M. Sundin or Dr. Reps B. Sundin and/or Virginia Institute of Plastic Surgery, PC.

X. All transactions-payments are nonrefundable 48 hours after payment. If payment is not applied to originally planned services, payment may be rendered for other goods and services available at VIPS.

XI: All financial credits will expire and be forfeited 365 days post payment unless an exception is provided in writing to the patient.

Initials _____

NOTICE REGARDING NEED FOR EMERGENCY PROCEDURES AND/OR FUTURE REVISIONS

I understand that I will be responsible for all facility and anesthesia fees incurred for subsequent revision and/or emergency procedures performed on me or my dependent, the above named patient, as well as necessary supplies including but not limited to implants, unless otherwise specified by Dr. Burton M. Sundin or Dr. Reps B. Sundin. Any surgeon's fee that may be incurred for subsequent revision and/or emergency procedures will be addressed on a case-by-case basis. If any fees are waived, refunded or paid by the physician or office, this does not constitute an admission of guilt, malpractice or wrongdoing.

Initials _____

PATIENT NAME (PLEASE PRINT) _____

PATIENT SIGNATURE _____ DATE _____

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Notice of Privacy Practices and Patient Consent for Use and Disclosure of Protected Health Information

PATIENT NAME _____

DATE _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Virginia Institute of Plastic Surgery may use or disclose my protected health information for treatment, payment or health care operations – which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Virginia Institute of Plastic Surgery has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing the agreement. If I ask, Virginia Institute of Plastic Surgery will provide me with the most current *Notice of Privacy Practices.*

My signature below indicated that I have been given the chance to review such a copy of the *Notice of Privacy Practices.* My signature means that I agree to allow Virginia Institute of Plastic Surgery to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Virginia Institute of Plastic Surgery has taken action relying on this content.

SIGNATURE _____

DATE _____

Relationship to patient if signed by another party _____

DATE _____

You may obtain a copy of our *Notice of Privacy Practices'*, including any revisions of our *'Notice'* at any time by contacting: Virginia Institute of Plastic Surgery, 7611 Forest Avenue, Suite 210, Henrico, VA 23229, 804-290-0909.

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO INDIVIDUALS (FAMILY MEMBERS, NEXT OF KIN, SPOUSE, CARETAKERS)

I, _____, hereby authorize the below individuals to receive information regarding my medical treatment and condition. I recognize that in accordance with HIPAA no other individuals will receive information about my medical treatment or condition unless this form is updated appropriately.

_____

_____

_____

_____

Printed name: _____

Signature: _____

Date: _____

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NOTICE OF DEEMED CONSENT TO HIV AND HEPATITIS BLOOD TESTING

A law was enacted in Virginia in 1989 which authorizes health care providers to test their patients for HIV and Hepatitis antibodies when the health care provider is exposed to the body fluids of a patient in a manner which may, according to certain medical authority, transmit human immunodeficiency virus (HIV), the virus that causes Acquired Immunodeficiency Syndrome (AIDS) related disorders, and Hepatitis. Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the health care provider who may have been exposed. However, if such an exposure occurs, you will be informed before any of your blood is tested for HIV and Hepatitis antibodies. Pursuant to the provision, the testing will be explained to you, and you will be given the opportunity to ask any questions you might have.

The law also provides that if you should be exposed to body fluids of a health care provider in a manner which may, according to certain medical authority, transmit HIV and Hepatitis, the health care provider is deemed to have consented to such testing and to the release of the test results to you.

I have read and understand the above “Notice of Deemed Consent to HIV and Hepatitis Blood Testing”.

Patient’s Signature: _____

Date: _____

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INSURANCE RELEASE FORM

I authorize to any holder of medical or other information about me to release to my insurance carrier any information needed for this or any related item.

I hereby authorize, request, and assign payment directly to Virginia Institute of Plastic Surgery, PC for bills rendered by this office covering Dr. Sundin's services and any past and future treatments if related to the incident or condition giving rise to carriers with whom I have coverage or settlements or judgment flowing from the incident for which I am receiving treatment. This authorization shall include all benefits specified and/or master medical benefits otherwise payable to me.

I permit a copy of this authorization to be used in place of the original.

Name: _____

Signature: _____

Date: _____

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Informed Consent: COVID-19 RISK

I _____ (patient name) understand that I am opting for an elective treatment/procedure/surgery that is not urgent and may not be medically necessary. I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that Dr. Sundin and all the staff at Virginia Institute of Plastic Surgery/MBody are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for Dr. Sundin and all the staff at Virginia Institute of Plastic Surgery/MBody to proceed with the same. I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus, or I may have contracted COVID after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure/surgery can lead to a higher chance of complication and death. I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital. I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself. have been given the option to defer my treatment/procedure/surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery.

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.

Patient's Signature: _____ Date: _____

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coolsculpting®

INFORMATION AUTHORIZATION FORM

By signing below, I hereby authorize my CoolSculpting® physicians (Burton Sundin MD & Reps Sundin MD), health care professionals, or other health care providers (collectively, my "Health Care Providers") to disclose and transmit my protected health information to Allergan and/or its designated service providers (collectively, "Allergan") in order for Allergan to: (i) help enable my treatment and provide me with communications about my treatment (ii) operate, administer, register me in and/or provide me with access to Allergan programs and services; (iii) identify products and services that may be of interest to me and to provide me with communications about any such products and services; and (iv) develop, evaluate and improve products, services, materials and programs related to my condition or treatment. I authorize any protected health information disclosed by my Health Care Providers pursuant to this authorization to be transmitted electronically in whatever form and through whatever media, including the internet, as required by the purposes set forth. This authorization is made pursuant to

45 CFR § 164.524.

Print
Name: _____ Signature: _____ Date: _____

CSC152094 11/21

Please refer to the Allergan Privacy Statement at www.allergan.com/privacy and the California Privacy Policy at www.allergan.com/privacy/ccpa

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coolsculpting®

TREATMENT CONSENT FORM

The CoolSculpting® procedure is a non-invasive procedure that is intended to break down fat cells that are just beneath the skin by delivering controlled cooling at the surface of the skin. This procedure is not a treatment for weight loss. The CoolSculpting procedure does not replace traditional methods such as diet, exercise, or liposuction.

Initial: ____

Clinical studies have shown that the CoolSculpting procedure can break down fat cells to change the appearance of visibly localized bulges of fat that is just beneath the skin on the submental (under the chin) and submandibular (under the jawline) areas, thigh, abdomen and flank, along with bra fat, back fat, underneath the buttocks (also known as the banana roll) and upper arm. Following the procedure, the treated fat cells are naturally processed by the body over a period of months. Visible results can vary from person to person.
Initial: ____

WHAT YOU CAN EXPECT:

Temporary Sensations / Symptoms:

The following effects can happen frequently in the treatment area during and after a treatment. These effects are temporary and generally resolve within days or weeks.

»These side effects can happen during a treatment:

- The suction pressure of a vacuum applicator may cause sensations of deep pulling, tugging, and pinching. A surface applicator may cause sensations of pressure. You may experience intense cold, stinging, tingling, aching, or cramping as the treatment begins. These sensations generally lessen during treatment as the area becomes numb.
  Initial: ____

»These side effects can happen immediately after a treatment:

- The treated area may look or feel stiff after the procedure and transient blanching (temporary whitening of the skin) may happen. **Initial:** ____
- Bruising, redness, firmness, cramping, tingling, and stinging may happen. **Initial:** ____

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»These side effects can happen one to two weeks after a treatment:

- You may feel numbness in the treated area that can last for several weeks after the procedure. Prolonged redness, swelling, itching, tingling, numbness, tenderness to the touch, pain in the treated area, cramping, aching, bruising, and/or skin sensitivity have also been reported. **Initial:** ____
- You may have a feeling of fullness in the back of the throat. (Initial if the submental area is to be treated. If the area under the chin or jawline is not being treated, please write N/A). **Initial:** ____

These other side effects can happen within one to two weeks after submental (under the chin) and submandibular (under the jawline) area treatments:

- Cold exposure to a nerve close to your tongue called the hypoglossal nerve may cause tongue deviation (turning). **Initial:** ____

- Cold exposure to a nerve in the face called the marginal mandibular nerve may cause lower lip weakness. **Initial:** ____

- Cold exposure to a gland below the jaw called the submandibular gland may cause dry mouth or a decrease in saliva production in your mouth. **Initial:** ____

Potential Side Effects / Risks

The following side effects can happen in the treatment area during and after a treatment. The risk for the side effects listed below is small, but possible.

We can estimate how likely these side effects could happen. We do this by first counting how many of these side effects have been reported by people treated with CoolSculpting® or CoolSculpting® Elite. Then we count the number of treatment cycles of CoolSculpting® and CoolSculpting® Elite used around the world.

Rare side effects are not reported by people as often and this can make them difficult to measure. We have provided estimates for how likely a side effect may happen. These are listed in the parentheses below.

Rare side effects may happen in 1-10 out of 10,000 CoolSculpting® treatments (between 0.01% to 0.1%). These include:

» **Paradoxical hyperplasia** (About 1 out of 3,000 treatments, 0.033%) **Initial:** _____

A small percentage of patients have experienced gradual development of visibly enlarged tissue in the treatment area. The enlarged tissue may feel hard and may appear in the shape of the applicator used during CoolSculpting® treatment. This may appear two to five months after treatment, is distinguishable from temporary swelling and will not resolve on its own. Surgical intervention may be required.

» **Late-onset pain** (About 1 out of 6,000 treatments, 0.017%) **Initial**:_____

This has a typical onset several days after a treatment and resolution within several weeks.

» **Severe pain** (About 1 out of 6,000 treatments, 0.017%) **Initial**:_____

Patients may experience pain of varying severity, which more commonly can be described as mild to moderate, and in rare instances can be severe.

Very rare side effects may happen in less than 1 out of 10,000 CoolSculpting® treatments (less than 0.01%). These include:

» Some patients have reported the following conditions in areas of the body treated with CoolSculpting®: hardness, discrete nodules, burns, frostbite (local injury due to cold), nerve pain, skin laxity, extensive tissue damage, and fat tissue death. Surgical intervention may be required to address these conditions if they develop. More details are provided below. **Initial**_____

» **Hyperpigmentation** (About 1 out of 11,000 treatments, 0.009%) **Initial:** ____

Dark coloration of the skin may happen after treatment. Typically, it resolves spontaneously.

» **Freeze burn or "frostbite"** (About 1 out of 15,000 treatments, 0.006%) **Initial:**_____

First- and second-degree freeze burn may happen during treatment. It typically resolves without additional side effects with proper care. Surgical intervention may be required to address this condition if it develops.

» **Subcutaneous induration** (About 1 out of 30,000 treatments, 0.003%) **Initial:** ____

Generalized hardness and/or discrete nodules within the treatment area, which may develop after the treatment and may be accompanied by pain and/or discomfort.

» **Cold panniculitis** (About 1 out of 60,000 treatments, 0.002%) **Initial:** ____

Cold panniculitis results from injury to adipose tissue exposed to cold and may result in a mild to severe inflammatory response. In mild cases, the symptoms are self-resolving and may include redness, swelling, skin nodules, warmth, tenderness, and possible low-grade fever. These cases typically resolve without long-term side effects. In more severe cases, an intense inflammatory response may result in more extensive tissue damage, including fat tissue death, which may require medical or surgical intervention.

» **Treatment area demarcation** (About 1 out of 20,000 treatments, 0.005%) **Initial**: ____
A small percentage of patients have experienced excessive fat removal in the treatment area, resulting in an unwanted indentation. The indentation may be improved through corrective procedures.

7611 Forest Ave · Suite 210
Richmond, VA 23229
(804) 290-0909
Fax (804) 290-0333
www.DrSundin.com

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MODERN BODY CONTOURING AND LASER CENTER

1500 Cornerside Blvd · Suite 400
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(703) 740-8333
Fax (703) 740-8775
www.MyModernBody.com

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» **Vasovagal symptoms** (About 1 out of 30,000 treatments, 0.003%) **Initial:** ____

You may have dizziness, light-headedness, nausea, flushing, sweating, or fainting during or immediately after the treatment.

» **Hernia** (About 1 out of 185,000 treatments, 0.001%) **Initial:** ____

Some patients have reported development of a hernia, or worsening of an existing hernia, following CoolSculpting treatment. Surgical intervention may be required to correct hernia formation or exacerbation.

» Patient experiences may vary. Some patients may experience a delayed onset of the previously mentioned symptoms. Contact your physician immediately if any unusual side effects occur or if symptoms worsen over time. **Initial:** ____

» I understand that any of these known side effects may occur and there is no way to predict who may experience them. **Initial:** _____

» I understand that other unknown side effects may also occur following CoolSculpting® treatment, but elect to voluntarily proceed with CoolSculpting®. **Initial:** _____

» No one associated with the medical practice or the manufacturer of CoolSculpting® has provided any information which contradicts any of the risks that have just been described. **Initial:** _____

Results

» You may start to see changes in as early as 1-3 months after your CoolSculpting procedure. Your body will continue to naturally process the injured fat cells from your body for months after your procedure. **Initial:** ____

» Results vary from person to person. You may decide that additional treatments are necessary to achieve your desired outcome. Although highly unlikely, it is possible that you will not experience any noticeable result from the procedure. **Initial:** ____

» Particular results cannot be guaranteed, given that each individual's body may react differently to stimuli. **Initial:** ____

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Do you currently have or have had any of the following?

» Cryoglobulinemia (a condition in which an abnormal level of proteins thicken the blood in cold temperatures), or paroxysmal cold hemoglobinuria or cold agglutinin disease (blood disorders in which cold temperatures lead to red blood cell death). ……...**Yes / No**

» Known sensitivity to cold such as cold urticaria (hives triggered by cold), Raynaud's disease (disorder in which cold leads to reduced blood flow in the fingers, which appear white, red, or blue), pernio or Chilblains (itchy and/or tender red or purple bumps that occur as a reaction to cold). ……....**Yes / No**

» Poor blood flow in the area to be treated ……...**Yes / No**

» Neuropathic (nerve) disorders such as post-herpetic neuralgia (pain in the areas of your skin where you had shingles) or diabetic neuropathy (nerve pain from diabetes)……...**Yes / No**

» Impaired skin sensation ……...**Yes / No**

» Open or infected wounds ……...**Yes / No**

» Bleeding disorders or use of blood thinners ……...**Yes / No**

» Recent surgery or scar tissue in the area to be treated……....**Yes / No**

» A hernia or history of hernia in the area to be treated or adjacent to treatment site ……...**Yes / No**

» Skin conditions such as eczema, dermatitis, or rashes……....**Yes / No**

» Pregnancy or lactation (making breast milk or breast feeding) ……...**Yes / No**

» Any active implanted devices such as pacemakers and defibrillators ……....**Yes / No**

» Any major health problems such as liver disease ……...**Yes / No**

» Any known sensitivity to fructose, glycerin, isopropyl alcohol (rubbing alcohol) or propylene glycol **Yes / No**

» Any chronic pain ……...**Yes / No**

» Any anxiety disorder ……...**Yes / No**

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Pictures will be obtained for medical records. If pictures are used for education and marketing purposes, all identifying marks will be cropped or removed. **Initial:** ____

As with most medical procedures, there are risks and side effects. These have been explained to me in detail. I accept these risks by proceeding with this elective treatment. I have read the above information, and I give my consent to be treated with the CoolSculpting® procedure by the physician(s) (Dr. Burton Sundin and/or Dr. Reps Sundin) in this practice (Virginia Institute of Plastic Surgery/MBODY) and his/her designated staff.

Print
Name: _____ Signature:_____ Date: _____

Witness
Print
Name: _____Signature:_____ Date: _____

Physician(s): Burton Sundin MD & Reps Sundin MD. Practice: Virginia Institute of Plastic Surgery/MBODY.

Signature _____