**Patient Ledger**

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| Additional Notes: |

**E-Matrix Sublative Skin Treatment**

Tiny scabs of less than 1 mm in diameter will usually form 12-72 hours post treatment and will remain for several days. The scabs should not be touched or scratched and should be allowed to shed off naturally. A hive-like reaction and grid-shaped pattern will also form.

During the first seven days after treatment, care should be taken to prevent trauma to the treated site: Do not use scrubs, course wash cloths, lufas, microderm crystals, ClariSonics, or anything abrasive or that could prematurely peel the skin.

Anything that produces more heat in the skin should be avoided for five days: hot baths, steam rooms, saunas, hot showers and hot tubs. The gym should also be avoided for 24-48 hours.

Cleanse skin the following morning post treatment with our gentle cleanser. The skin should be kept clean (cleanse twice a day) to avoid contamination, or infection. Any mechanical or thermal damage to the area must be avoided.

Our medical grade barrier ointment or reconstructive cream should be applied several hours (1/2 day) after each treatment, and then should be applied regularly throughout the course of the treatment. Mineral Make-Up or a light powder may be applied the following day post treatment, unless there is a lot of swelling and redness still present.

Post treatment cooling is not necessary. Cooling the skin can interfere with collagen rebuilding. In the event of major post-treatment discomfort, you can then apply cooling to the treated areas.

The patient should use an approved sunscreen to protect the treated areas from sunlight for at least one month post treatment. Tanning or UV exposure of any sort (sun exposure, tanning beds, and artificial sunless tanning lotions) is not allowed in the treated areas during the entire course of the healing process. UV exposure post treatment may cause hyperpigmentation.

I have read and understand the post-treatment protocol for E-Matrix skin treatment and all subsequent E-Matrix treatments.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Date

Copy given to Patient, Employee Initial:

**E-Matrix Sublative Skin Treatment**

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I have read and understand the post-treatment protocol for E-Matrix skin treatment and all subsequent E-Matrix treatments.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Date

Copy given to Patient, Employee Initial:

**EMATRIX INFORMED CONSENT FORM**

Patient name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment site\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I duly authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to perform **eMatrix** treatment. I understand that the

 **eMatrix** is a device used for dermatologic procedures requiring ablation of soft tissue and skin resurfacing, of

which I am consenting to be a patient receiving treatment\_\_\_\_\_\_(patient’s initials)

I understand that clinical results may vary depending on individual factors, including but not limited to medical

history, skin type, patient compliance with- and post-treatment instructions, and individual response to treatment.\_\_\_\_\_(patient’s initials)

I understand that there is a possibility of short-term or long term effects such as reddening,

swelling, blister formation, temporary discoloration of the skin, as well as the possibility of rare

side effects such as burn, scarring and permanent discoloration. These effects have been fully

explained to me \_\_\_\_(patient’s initials)

I understand that the treatment with the **eMatrix** involves a series of treatments and the fee

structure has been fully explained to me \_\_\_\_\_\_(patient’s initials)

I certify that I have been fully informed of the nature and purpose of the procedure, expected

outcome and possible complications, and I understand that no guarantee can be given as to the

final results obtained . I am fully aware that my condition is of cosmetic concern and that the

decision to proceed is based solely on my expressed desire to do so\_\_\_\_\_\_\_\_(patient’s initials)

I confirm that I have informed the staff regarding any current or past medical condition,

diseases or medication taken, as well as many past and planned exposure to sun, sun-bed, and

tanning creams

\_\_\_\_(patient’s initials)

I consent to the taking of photographs and authorize their anonymous use of the purposes of

medical audit, education and promotion \_\_\_\_\_\_\_(patient’s initials)

I certify that I have been given the opportunity to ask questions and that I have read and fully

understand the contents of this consent form \_\_\_\_(patient’s initials).

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_

Witness Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Laser Services Treatment Record

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Skin Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Technician Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Laser Type | Service Type | N.A.M.E.S. |
| * Alexandrite
* YAG
* E-Matrix
 | * HR: Hair Removal
* SL: Skin Lightening
* ST: Skin Tightening
* EM: E-Matrix
* O: Other/Vein/Moles/Ect.
 | **N:** Any **New** medications, illnesses, or allergies since your last visit?**A:** Did you have any **Adverse** reactions from your last treatment?**M:** Are you on your **Menstrual** cycle or hormonal medications?**E:** Since your last treatment did you **Experience** a) reduction in hair growth or b) desired results from the laser?**S:** When were you in the **Sun** or tanning last? |

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| Date | NAMES | Laser Type | Service Type | Tx # | Treatment Area | Spot Size (mm) | Fluence(mj) | DCD | MS/Hz | Treatment Notes | Staff Initials |
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|  Additional Notes: |

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Kevin G. Rose M.D.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_

DOB\_\_\_\_/\_\_\_\_/\_\_\_\_ Weight\_\_\_\_\_ Age \_\_\_\_\_ Ht.\_\_\_\_\_\_ Gender: 🞎Male 🞎Female

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone#: ( )\_\_\_\_\_-\_\_\_\_\_\_

Work #: ( )\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Ext: \_\_\_\_\_\_ Cell #: ( )\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of employment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance Co. name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact # :( ) \_\_\_\_\_\_ -\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation:\_\_\_\_\_\_\_\_\_\_\_

Do you have any known medical allergies?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications (Prescription, over-the-counter, or herbal supplements) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What will we be seeing you for/procedure of interest?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\***How did you hear about us?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all skin care products you are currently using (prescription and/or over the counter:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently pregnant? Yes No

When was the last time you were exposed to UV light? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any illnesses or sicknesses? If yes, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any previous skin care treatments you have tried along with the outcome of the treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize The Rose Clinic to contact me or anyone at the above number(s) and/or address (s) for correspondence, information, messages or confirmation appointments.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_



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| Patient Name: Treatment: Treatment Number:I acknowledge that I have read the informed consent for the above listed procedure and wish to proceed with my treatment today.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Signature Date |
| Patient Name: Treatment: Treatment Number:I acknowledge that I have read the informed consent for the above listed procedure and wish to proceed with my treatment today.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Signature Date |
| Patient Name: Treatment: Treatment Number:I acknowledge that I have read the informed consent for the above listed procedure and wish to proceed with my treatment today.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Signature Date |
| Patient Name: Treatment: Treatment Number:I acknowledge that I have read the informed consent for the above listed procedure and wish to proceed with my treatment today.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Signature Date |

**DISPUTE RESOLUTION AGREEMENT**

**Article 1 Dispute Resolution**

By signing this Agreement (“Agreement”) we are agreeing to resolve any Claim for medical malpractice by the dispute resolution process described in this agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a judge or a jury.

**Article 2 Definitions**

1. The term “we,” “parties” or “us” means you, (the Patient), and the Provider.
2. The term “Claim” means one or more Malpractice Actions defined in the Utah Health Care Malpractice Act (Utah Code 78-14-3(15)). Each party may use any legal process to resolve non-medical malpractice claims.
3. The term “Provider” means Kevin G. Rose, M.D. (“Dr. Rose”) and any person or entity employed by The Rose Clinic as well as independent persons or entities not employed by The Rose Clinic whose practice is primarily plastic and migraine surgery.
4. The term “Patient” or “you” means:
	1. you and any person who makes a Claim for care given to YOU, such as your heirs, your spouse, children, parents or legal representatives, AND
	2. your unborn child or newborn child for care provided during the 12 months immediately following the date you sign this Agreement, or any person who makes a Claim for care given to that unborn or newborn child.

**Article 3 Dispute Resolution Options**

1. Methods Available for Dispute Resolution. We agree to resolve any Claim by:
	1. working directly with each other to try and find a solution that resolves the Claim, OR
	2. using non-binding mediation (each of us will bear one-half of the costs); or
	3. using binding arbitration as described in this Agreement.

You may choose to use any or all of these methods to resolve your Claim.

1. Legal counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and costs of our own attorney.
2. Arbitration – Final Resolution. If working with the Provider or using non-binding mediation does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that the decision reached in binding arbitration will be final.

**Article 4 How to Arbitrate a Claim**

1. Notice. To make a Claim under this Agreement, mail a written notice to the Provider by certified mail that briefly describes the nature of your Claim (the “Notice”). If the Notice is sent to the Provider by certified mail it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this Agreement.
2. Arbitrators. Within 30 days of receiving the Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the Claim.
	1. Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.
	2. Jointly-Selected Arbitrator. You and the Provider(s) will then jointly appoint an arbitrator (the “Jointly-Selected Arbitrator”). If you and the Provider(s) cannot agree upon a Jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly-Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal courts of Utah. If the arbitrators cannot agree on a Jointly-Selected Arbitrator, either or both of us may request that a Utah court select an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly-Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Utah Uniform Arbitration Act.
3. Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of the arbitrator the Provider(s) appoints. Each of us will also pay one-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.
4. Final and Binding Decision. A majority of the three arbitrators will make a final decision on the Claim. The decision shall be consistent with the Utah Uniform Arbitration Act.
5. All claims May be Joined. Any person or entity that could be appropriately named in a court proceeding (“Joined Party”) is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration decision (“joinder”). Joinder may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A “Joined Party” does not participate in the selection of the arbitrators but is considered a “Provider” for all other purposes of this Agreement.

**Article 5 Liability and Damages May be Arbitrated Separately.**

At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected, the Jointly Selected arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

**Article 6 Venue/Governing Law**

The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Utah County, State of Utah. Arbitration proceedings are private and shall be kept confidential. The provisions of the Utah Uniform Arbitration Act and the Federal Arbitration Act govern this Agreement. We hereby waive the prelitigation panel review requirements. The arbitrators will apportion fault to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

**Article 7 Term/Rescission/Termination**

1. Term. This Agreement is binding on both of us for one year from the date you sign it unless you rescind. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it.
2. Rescission. You may rescind this Agreement within 10 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date it is postmarked. The notice shall be mailed to **320 West River Park Drive, Suite 245 Provo, Utah 84604** and must include your name, birth date and signature. If not rescinded, this Agreement will govern all medical services received by the Patient from Provider after the date of signing, except in the case of a Joined Party that provided care prior to the signing of the agreement (see Article 4(E)).
3. Termination. If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered or certified mail to**, 320 West River Park Drive, Suite 245 Provo Utah 84604**. You must include your name, birth date and signature. This Agreement applies to any Claim that arises while it is in effect, even if you file a Claim or request arbitration after the Agreement has been terminated.

**Article 8 Severability**

If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

**Article 9 Acknowledgment of Written Explanation of Arbitration**

I have received a written explanation of the terms of this Agreement. I have had the right to ask questions and have my questions answered. I understand that any claim I might have must be resolved through the dispute resolution process in this Agreement instead of having them heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration related costs. I understand that this Agreement renews each year unless canceled before the renewal date. I understand that I can rescind this Agreement within 10 days of signing it.

**Article 10 Receipt of Copy**

I have received a copy of this document.

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dr. Kevin G. Rose

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Provider Printed Name of Patient

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Signed By: Signature of Patient or Patient’s

 Representative