B 10 (Official Form 10) (12/11)

UNITED STATES BANKRUPTCY COURT District of Delaware		PROOF OF CLAIM
Name of Debtor: CLA of Pennsylvania LLC (CLA Hold LLC, f/k/a ALC Holdings)	Case Number: 11-13875	2012 FEB 17 AM 10:20 CLERK US BANKRUPTCY COURT DISTRICT OF DELAWARE
NOTE: *Do not use this form to make a claim for an administrative expense that arises after the bankruptcy filing. You may file a request for payment of an administrative expense according to 11 U.S.C. § 503.*		
Name of Creditor (the person or other entity to whom the debtor owes money or property): Mai-Ellen Mayson		COURT USE ONLY
Name and address where notices should be sent: Andrew D. Swain, Esq., The Swain Law Firm, PC 2410 Bristol Road, Bensalem, PA 19020 Telephone number: (215) 702-2708 email: swain@swainlawfirm.com		☐ Check this box if this claim amends a previously filed claim. Court Claim Number: _____ (*If known*) Filed on: _____
Name and address where payment should be sent (if different from above): Telephone number: email:	RECEIVED MAR 01 2012 BMC GROUP	☐ Check this box if you are aware that anyone else has filed a proof of claim relating to this claim. Attach copy of statement giving particulars.

1. **Amount of Claim as of Date Case Filed:** $ 10,000,000.00

If all or part of the claim is secured, complete item 4.

If all or part of the claim is entitled to priority, complete item 5.

☐ Check this box if the claim includes interest or other charges in addition to the principal amount of the claim. Attach a statement that itemizes interest or charges.

2. **Basis for Claim:** Personal Injury Claim arising from misuse of a laser, etc.
(See instruction #2)

3. Last four digits of any number by which creditor identifies debtor:	3a. Debtor may have scheduled account as: (See instruction #3a)	3b. Uniform Claim Identifier (optional): (See instruction #3b)

4. **Secured Claim** (See instruction #4)
Check the appropriate box if the claim is secured by a lien on property or a right of setoff, attach required redacted documents, and provide the requested information.

Amount of arrearage and other charges, as of the time case was filed, included in secured claim, if any: $ _____

Nature of property or right of setoff: ☐ Real Estate ☐ Motor Vehicle ☐ Other
Describe:

Basis for perfection: _____

Value of Property: $ _____

Amount of Secured Claim: $ _____

Annual Interest Rate _____ % ☐ Fixed or ☐ Variable
(when case was filed)

Amount Unsecured: $ _____

5. **Amount of Claim Entitled to Priority under 11 U.S.C. § 507 (a). If any part of the claim falls into one of the following categories, check the box specifying the priority and state the amount.**

☐ Domestic support obligations under 11 U.S.C. § 507 (a)(1)(A) or (a)(1)(B).

☐ Wages, salaries, or commissions (up to $11,725*) earned within 180 days before the case was filed or the debtor's business ceased, whichever is earlier – 11 U.S.C. § 507 (a)(4).

☐ Contributions to an employee benefit plan – 11 U.S.C. § 507 (a)(5).

Amount entitled to priority:
$ _____

☐ Up to $2,600* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use – 11 U.S.C. § 507 (a)(7).

☐ Taxes or penalties owed to governmental units – 11 U.S.C. § 507 (a)(8).

☐ Other – Specify applicable paragraph of 11 U.S.C. § 507 (a)(__).

ALC Holdings
00143

**Amounts are subject to adjustment on 4/1/13 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.*

6. **Credits.** The amount of all payments on this claim has been credited for the purpose of making this proof of claim. (See instruction #6)

BMC

7. **Documents:** Attached are **redacted** copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. If the claim is secured, box 4 has been completed, and **redacted** copies of documents providing evidence of perfection of a security interest are attached. *(See instruction #7, and the definition of "**redacted**".)*

DO NOT SEND ORIGINAL DOCUMENTS. ATTACHED DOCUMENTS MAY BE DESTROYED AFTER SCANNING.

If the documents are not available, please explain:

8. **Signature:** (See instruction #8)

Check the appropriate box.

☑ I am the creditor. ☐ I am the creditor's authorized agent. (Attach copy of power of attorney, if any.) ☐ I am the trustee, or the debtor, or their authorized agent. (See Bankruptcy Rule 3004.) ☐ I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: Mai-Ellen Mayson
Title:
Company:
Address and telephone number (if different from notice address above):
2151 E. Lincoln Hwy, Apt N-8
Levittown, PA 19056
Telephone number: (215) 500-5191 email: maimayson2000@yahoo.com

Mai-Ellen Mayson (Signature) 2/14/12 (Date)

Penalty for presenting fraudulent claim: Fine of up to $500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 and 3571.

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The instructions and definitions below are general explanations of the law. In certain circumstances, such as bankruptcy cases not filed voluntarily by the debtor, exceptions to these general rules may apply.

Items to be completed in Proof of Claim form

Court, Name of Debtor, and Case Number:
Fill in the federal judicial district in which the bankruptcy case was filed (for example, Central District of California), the debtor's full name, and the case number. If the creditor received a notice of the case from the bankruptcy court, all of this information is at the top of the notice.

Creditor's Name and Address:
Fill in the name of the person or entity asserting a claim and the name and address of the person who should receive notices issued during the bankruptcy case. A separate space is provided for the payment address if it differs from the notice address. The creditor has a continuing obligation to keep the court informed of its current address. See Federal Rule of Bankruptcy Procedure (FRBP) 2002(g).

1. Amount of Claim as of Date Case Filed:
State the total amount owed to the creditor on the date of the bankruptcy filing. Follow the instructions concerning whether to complete items 4 and 5. Check the box if interest or other charges are included in the claim.

2. Basis for Claim:
State the type of debt or how it was incurred. Examples include goods sold, money loaned, services performed, personal injury/wrongful death, car loan, mortgage note, and credit card. If the claim is based on delivering health care goods or services, limit the disclosure of the goods or services so as to avoid embarrassment or the disclosure of confidential health care information. You may be required to provide additional disclosure if an interested party objects to the claim.

3. Last Four Digits of Any Number by Which Creditor Identifies Debtor:
State only the last four digits of the debtor's account or other number used by the creditor to identify the debtor.

3a. Debtor May Have Scheduled Account As:
Report a change in the creditor's name, a transferred claim, or any other information that clarifies a difference between this proof of claim and the claim as scheduled by the debtor.

3b. Uniform Claim Identifier:
If you use a uniform claim identifier, you may report it here. A uniform claim identifier is an optional 24-character identifier that certain large creditors use to facilitate electronic payment in chapter 13 cases.

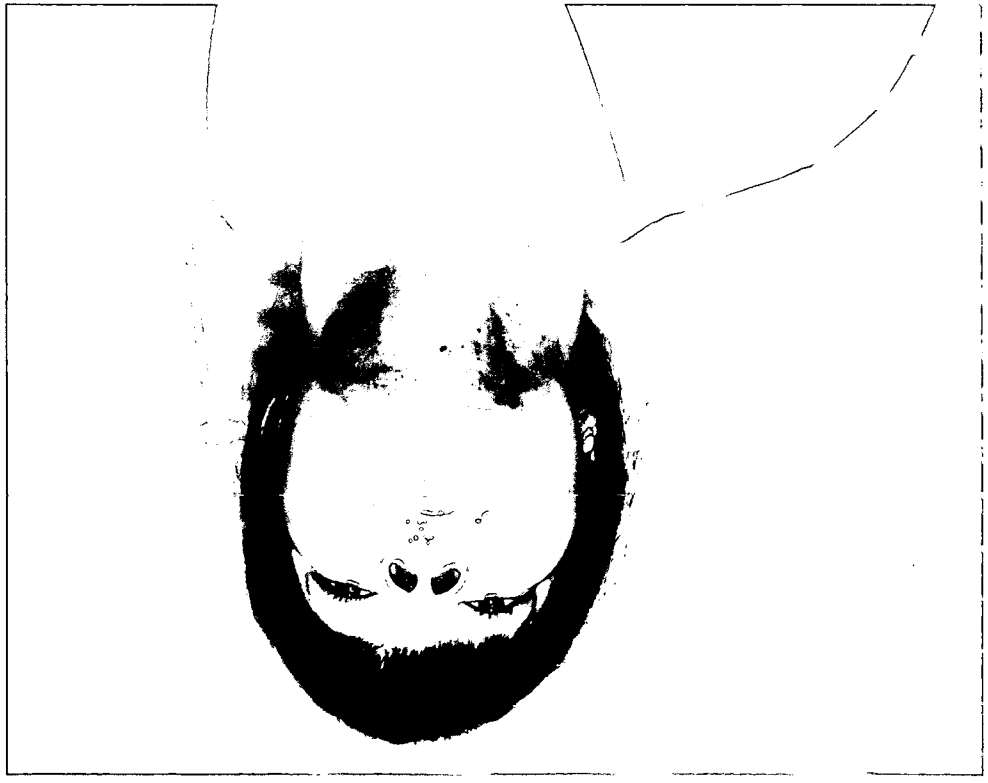
4. Secured Claim:
Check whether the claim is fully or partially secured. Skip this section if the claim is entirely unsecured. (See Definitions.) If the claim is secured, check the box for the nature and value of property that secures the claim, attach copies of lien documentation, and state, as of the date of the bankruptcy filing, the annual interest rate (and whether it is fixed or variable), and the amount past due on the claim.

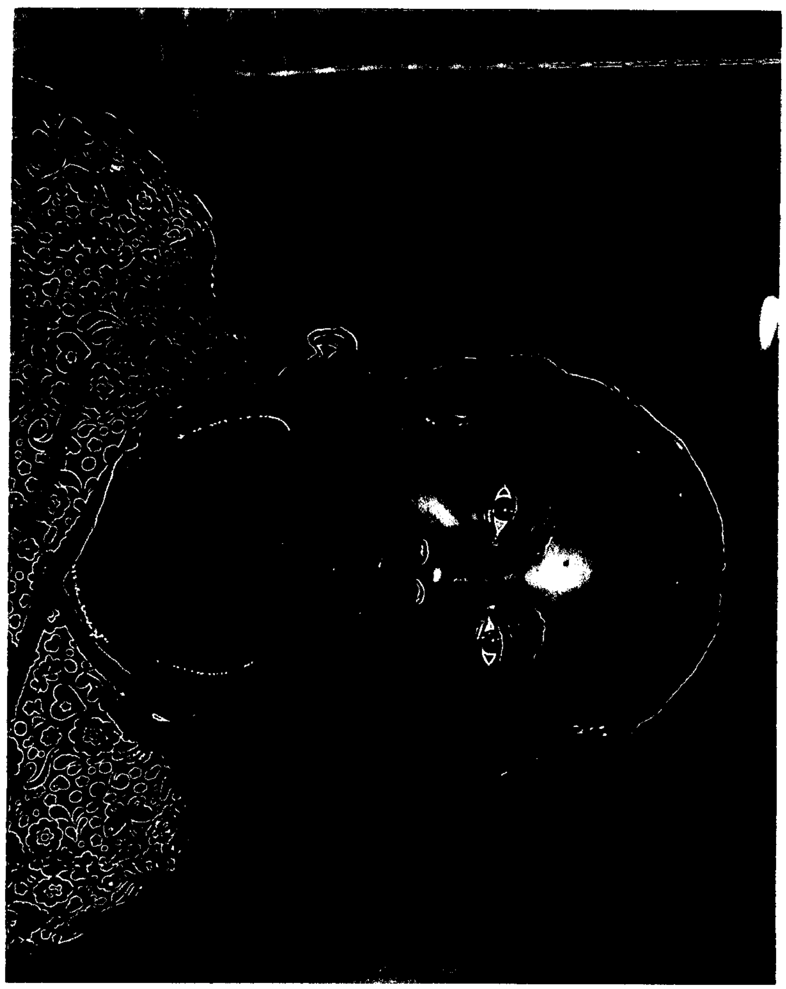
5. Amount of Claim Entitled to Priority Under 11 U.S.C. § 507 (a).
If any portion of the claim falls into any category shown, check the appropriate box(es) and state the amount entitled to priority. (See Definitions.) A claim may be partly priority and partly non-priority. For example, in some of the categories, the law limits the amount entitled to priority.

6. Credits:
An authorized signature on this proof of claim serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

7. Documents:
Attach redacted copies of any documents that show the debt exists and a lien secures the debt. You must also attach copies of documents that evidence perfection of any security interest. You may also attach a summary in addition to the documents themselves. FRBP 3001(c) and (d). If the claim is based on delivering health care goods or services, limit disclosing confidential health care information. Do not send original documents, as attachments may be destroyed after scanning.

8. Date and Signature:
The individual completing this proof of claim must sign and date it. FRBP 9011. If the claim is filed electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what constitutes a signature. If you sign this form, you declare under penalty of perjury that the information provided is true and correct to the best of your knowledge, information, and reasonable belief. Your signature is also a certification that the claim meets the requirements of FRBP 9011(b). Whether the claim is filed electronically or in person, if your name is on the signature line, you are responsible for the declaration. Print the name and title, if any, of the creditor or other person authorized to file this claim. State the filer's address and telephone number if it differs from the address given on the top of the form for purposes of receiving notices. If the claim is filed by an authorized agent, attach a complete copy of any power of attorney, and provide both the name of the individual filing the claim and the name of the agent. If the authorized agent is a servicer, identify the corporate servicer as the company. Criminal penalties apply for making a false statement on a proof of claim.





American Laser Centers

August 8, 2010
RE: Client Medical Information

Neal E. Newman
86 Buck Road
Holland, PA 18966

Dear Mr. Newman:

Per your request, enclosed please find a copy of Ms. Mai-Ellen Mayson's chart from American Laser Centers. Should you have any further questions or concerns, please do not hesitate to contact me.

Sincerely,

Amber French
Paralegal

American Laser Centers

Client Name: Mai-ellen Mayson Date of Birth. -80

Do you have or have you ever had any of the following conditions:

Yes	No	Medical History	Please Specify
☐	☑	Seizures and/or Epilepsy	
☐	☑	Diabetes	
☐	☑	Numbness in the area	
☐	☑	Autoimmune Disorders	
☐	☑	Sarcoidosis	
☐	☑	Lupus	
☐	☑	Scleroderma	
☐	☑	Skin Disorders	
☐	☑	Vitiligo	
☐	☑	Keloid/Hypertrophic Scarring	
☑	☐	Present Scarring	Due to car accident in 2003
☐	☑	Herpes Virus /Cold Sores	
☐	☑	Polycystic Ovarian Syndrome	
☐	☑	Blood clots/Phlebitis/Bleeding Disorders	
☐	☑	Peripheral Vascular Disease	
☐	☑	Lymphedemia	
☐	☑	Varicose Veins	
☐	☑	Pregnancy/Actively trying to get pregnant	
☐	☑	Cancer and/or precancerous lesions	

Yes	No	Medical Clearance Letter Required	Please Specify
☐	☑	HIV/AIDS	
☐	☑	Multiple Sclerosis	
☐	☑	Chemotherapy/radiation therapy	

Yes	No	Surgical History	Please Specify
☐	☑	Pacemakers/internal pacing devices	
☐	☑	Internal Metal Devices (rod,plates,screws)	
☐	☑	Hip Replacements	
☐	☑	Lymph Node Removal	
☐	☑	Hernias	
☐	☑	Past Surgeries	

Yes	No	Medication History	Please Specify
☐	☑	Current Medications	
☐	☑	Over-the-counter medications	
☐	☑	Herbal Supplements	
☐	☑	Retin-A or Generics	
☐	☑	Blood Thinner (Coumadin, Aspirin)	
☐	☑	Acne Medication	
☐	☑	Oral Contraceptives	
☐	☑	Accutane	Date:
☐	☑	Antibiotics	Date:

Yes	No	Allergies	Please Specify
☐	☑	Food Allergies	
☐	☑	Medication Allergies	
☐	☑	Latex Allergies	

Yes	No	Other	Please Specify
☐	☑	Permanent Make-up	
☐	☑	Tattoos	
☐	☑	Recent Cosmetic Procedures	Date:
☐	☑	Botox/Restylane/Dermal Fillers	Date:

Yes	No	Product History	Please Specify: *Brand Name*	*Frequency*
☐	☑	Cleanser		
☐	☑	Soap		
☐	☑	Toner		
☐	☑	Moisturizer		
☐	☑	Night Cream		
☐	☑	Eye Cream		
☐	☑	Astringent		
☐	☑	Scrub		
☐	☑	Sunscreen		
☐	☑	Other		

Type of Skin	☐ Dry	☐ Normal	☑ Oily	☐ Combination	☑ Acne-prone

I have answered all the questions truthfully and to the best of my knowledge

Client Signature: _____ Date: 12-5-09

American Laser Centers

Client Name: Mai-Ellen Mayson Date of Birth: 80

Address: 300 Horsham Road City: Hatfield State: PA Zip: 19040

Home Phone: 215-500-5191 Cell Phone: Same E-mail: MaiMayson2000@yahoo.com

Name of Employer: St. Mary Manor

Occupation: Nurse Work Phone: 267-663-4332

How did you hear about us? Yellow Pages

Emergency Contact Person: LadyMai Yancy

Relationship: Sister Phone: 215-317-6493

What method of payment is best for you? ☑ Financing ☐ Credit Card ☐ Check ☐ Cash

Please indicate the services and areas of interest

Laser Hair Removal

Area of Interest	Hair Color	Current Method of Hair Removal
facial	black	Shave & Hair removal creme

Skin Rejuvenation

Skin Tone	Firmness & Elasticity	Texture
☐ Uneven Skin Color	☐ Wrinkles ___Deep ___Fine	☐ Leathery Texture
☐ Sun Damage	☐ Lip Lines	☐ Acne Scarring
☐ Age Spots	☐ Crows Feet	☐ Large Pores
☐ Freckles	☐ Nasolabial Lines	☐ Blackheads
☐ Broken Capillaries	☐ Skin Tightening	☐ Dry/Rough Skin
☐ Rosacea	☐ Loss of Firmness/Elasticity	☐ Stretch Marks
Area of Interest	**Area of Interest**	**Area of Interest**

Cellulite Reduction / Body Contouring / Circumferential Reduction

Area of Interest	Area of Interest	Area of Interest
☐ Thighs	☐ Abdomen	☐ Arms
☐ Buttocks	☐ Hips	

American Laser Centers

Please circle the appropriate answers on this form so we can properly assess your skin type

Name Mai-Ann Mayson **Heritage** African

Score	0	1	2	3	4
What is the color of your eyes ?	Light blue, Green	Gray	Blue	Dark Brown	Brown/Black
What is your natural hair color ?	Sandy Red	Blonde	Chestnut/Dark Blonde	Dark Brown	Black
What is the color of your skin ?	Reddish	Very Pale	Pale	Light Brown	Dark Brown
Do you have freckles ?	Many	Several	Few	Incidental	None
				Total	

Score	0	1	2	3	4
What happens when overexposed to the sun ?	Redness/Blistering/Peels	Blistering/Peeling	Burns Sometimes/Peels	Rarely Burns	Never Burns
To what degree does your skin turn brown ?	Hardly/Not at all	Light Color Tan	Medium Tan	Tans Easily	Turn Dark Brown Quickly
Do you turn brown within several hours after sun exposure ?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun ?	Very Sensitive	Sensitive	Normal	Very Resistant	No Problem
				Total	

Score	0	1	2	3	4
When was your last exposure to sun, lamps or cream ?	More than 3 months	2 to 3 months	1 to 2 months	Less than 1 month	less than 2 weeks
Was the treatment area exposed ?	Never	Hardly Ever	Sometimes	Often	Always
				Total	

For each Parent of African American or East Indian descent add 10 points	10	20
If your heritage is Latin American, Asian-Pacific Islanders, Mediterranean, or native or indigenous to the Americas add 5 points	5	
Total		

Total for Genetic Disposition	
Total for Reaction to Sun Exposure	
Total for Tanning Habits	
Total for Heritage	
Skin Type Score	

***Suntanned skin overrides the skin type score.**

Skin Type Score	Skin Type
0 to 8	I
9 to 16	II
17 to 24	III
25 to 30	IV
31 to 34	V
35 and over	VI

Item # 213

Revised: 01/14/08

American Laser Centers

Laser Hair Removal | Skin Rejuvenation
Cellulite Reduction | Body Contouring

TREATMENT AND FINANCIAL AGREEMENT

Client Name: Marilyn Mayson Date: 6/7/2010

Service	# of Treatments	Treatment Area	Price	Discount	Final
LHR	2yr GT.	Chin	$1560	$ -560 00	

PAID $21.20 on 12/5/09
Bal $780.80

Total: Grand Total: 1000

- I fully understand and agree to treatment of the listed areas, and agree to pay American Laser Centers the price quoted above.
- If I have paid the price quoted using a credit program, I acknowledge that I selected the credit program based on my own evaluation of my options. I have not relied on any recommendation or advice of American Laser Centers or its staff with respect to financing. I understand that American Laser Centers has agreements with credit program providers but does not recommend credit products to customers.
- I clearly understand that my payment is for the procedure(s) performed during the term of the agreement and not for any specific result. If I have purchased a laser hair removal package, I will be eligible for the Appearance Plan once the treatments I purchased under this Agreement are completed.
- If no treatments are performed under this agreement, a refund will be issued after my written request.
- All payments are nonrefundable except as set forth in this agreement.

Balance as of 6/7/10 - $380.80

Client/Guardian Signature: _____ Date: 6-7-10

Staff Signature: _____ Date: 6/7/10

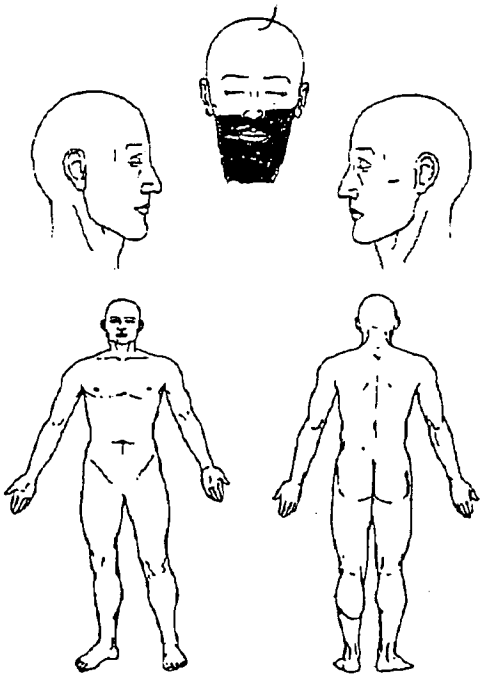
Treatment and Financial Agreement

American Laser Centers

Client Name: Mai-Ellen Mayson Date: 12-5-09

Notes: X 1010 X

Treatment Area	Price	Discount	Price	Product	Price
Chin	$ 1560	-60%			
Lip/upper	$ 600				
Neck/Front	$ 1920				
Face Sideburns	$ 1200				
Total	$ 5142.00	Total		Tax	
				Total	



Hair Removal
- ☐ Per Treatment - **Price Subject to Change** (Initial _____)
- ☐ Paid in Full - Package of 6 with 2 Year Guarantee

X pmts X 1010

FotoFacial
- ☐ Per Treatment - **Price Subject to Change** (Initial _____)
- ☐ Paid in Full - Package of 5 FotoFacials/5 Microdermabrasions

Skin Tightening
- ☐ Per Treatment - **Price Subject to Change** (Initial _____)
- ☐ Paid in Full - Package of _____ treatments

Affirm
- ☐ Per Treatment - **Price Subject to Change** (Initial _____)
- ☐ Paid in Full - Package of _____ treatments

Microdermabrasion
- ☐ Per Treatment - **Price Subject to Change** (Initial _____)
- ☐ Paid in Full - Package of _____ treatments

AmeriSmooth
- ☐ Per Treatment - **Price Subject to Change** (Initial _____)
- ☐ Paid in Full - Package of _____ treatments

Total Treatment Price $_____

Total Product Price $_____

Total Sales Price $ 2112.00

I fully understand and agree to the treatment areas that will be treated. If no services are performed under this agreement, a refund will be issued at customer's written request minus a ten percent administrative fee. Otherwise, all fees are nonrefundable. Guarantee for hair removal package takes effect on the day the sixth treatment is completed.

Client Signature: _____ Date: 12/5/09

Staff Signature: _____ Date: 12/5/09

APPLY ONE OF TWO WAYS: INSTANT CREDIT OR BY MAIL.
1.) To apply for INSTANT CREDIT today, complete the application and give it to provider 2) To apply by MAIL, complete the application and mail. Your application will be processed immediately upon receipt. Subject to credit approval.

APPLICANT – (PleasePrint) Name (First, Middle, Last)			Drivers License #	Expires
Mai-Ellen Mayson			Date of Birth 3/	Social Security No. 2352
Present Physical Address	City Hatboro	ST	Zip 19040	How Long? Yrs 1 Mos 2
Mailing Address (If other)	City Hatboro	ST Horsham	Zip 19040	How Long? Yrs Mos
Previous Address (If less than 2 years at present address)	City	ST	Zip	How Long? Yrs Mos
Circle your type of HOME: Own Rent Mobile Other	Current Rent /Mortgage Payment 575			Number of Dependents
Email Address*	Home Phone			Other Phone
Present Employer St. Mary Magdalen	Employee Verification Phone Number 267 663-4338			
Employer Address	City	ST	Zip	How Long?
Occupation or Title	Supervisor	Gross Yearly Income**		Gross Monthly Income**
Previous Employer (If less than two years)		Previous Employer Phone		How Long?
Name of Nearest Relative NOT Living With You		Relationship		Phone

By signing below, I represent that I am at least 18 years of age and that the information I have supplied on this application is true and correct. I agree that I am applying to World Financial Network National Bank (WFNNB) for a MedChoice Financial credit card account for personal, family or household use. I agree that a credit report may be obtained and used in making the credit granting decision. I agree to be bound by the terms of the Credit Card Agreement.

X Mai-Ellen Mayson 12-5-09
APPLICANT SIGNATURE DATE

The information described in the attached Credit Card Agreement is accurate as of July 1, 2008. This information may have changed after that date. To find out about changes in the information, call us at 1-866-397-7159 (TDD/TTY 1-800-695-1788), or write us at World Financial Network National Bank, PO Box 182273, Columbus, OH 43218-2273.

IMPORTANT INFORMATION ABOUT OPENING AN ACCOUNT
To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. What this means for you: When you open an account, we will ask for your name, address, date of birth or other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

The Ohio laws against discrimination require that all creditors make credit equally available to all creditworthy customers, and that credit reporting agencies maintain sperate credit histories on each individual upon request. The Ohio civil rights commission administers compliance with this law. **California Residents:** If you are married, you may apply for a seperate account. **New York Residents:** A consumer credit report may be ordered in connection with the processing of an application, or subsequently with the update, renewal or extension of credit. Upon your request, you will be informed of weather or not a consumer credit report was ordered, and if it was, you will be given the name and address of the consumer-reporting agency that furnished the report. **Rhode Island And Vermont Residents:** A consumer credit report may be ordered in connection with the processing of an application, or subsequently for purposes of review or collection of the account, increasing the credit line on the account, or other legitimate purposes associated with the account. **Notice to Married Wisconsin Residents:** No provision of any marital property agreement, unilateral statement under Section 766.59 of the Wisconsin statutes or court order under Section 766.70 adversely affects the intrest of the creditor, World Financial Network Bank, unless the Bank, prior to the time credit is granted is furnished a copy of the agreement, statement or decree or has actual knowledge of the adverse provision when the obligation to the Bank is incurred.

*By providing your email address, you consent to receive commercial emails from World Financial Network National Bank for solicitation, advertising and promotional offers related to your MedChoice Financial Credit Card Account. You also consent for World Financial Network National Bank to share your email address with MedChoice fo service and product offers.
** You do not have to tell us about alimony, child support, separate maintenance income or additional income unless you want us to consider them when we review your application.

9. Contraindications for this procedure include:

- ☐ Pregnancy and nursing
- ☐ Accutane (must discontinue use of product 3 months before beginning treatment)
- ☐ Epilepsy or those who have a history of seizures
- ☐ Diabetes (no treatment below the ankles and no shaving)
- ☐ Poorly controlled Diabetes
- ☐ Current history of skin cancer, or current condition of any other type of cancer, or pre-malignant moles in area of treatment
- ☐ Active sores or rash (psoriasis, eczema) in the area to be treated
- ☐ Skin disorders such as keloids or abnormal wound healing
- ☐ History of melanoma anywhere on the body
- ☐ Recent (within 3 months) surgery, laser resurfacing or deep chemical peels in treatment area
- ☐ Severe medical disorders such as poorly controlled heart conditions
- ☐ Chemo or radiation therapy (letter of clearance from your physician is required)
- ☐ Pacemaker, internal defibrillator and any internal electrical devices
- ☐ Any internal metal device, i.e. surgical screws, pins, plates, or implants, in the area to be treated (no treatment if the device is superficially in the body area to be treated)
- ☐ AIDS, HIV positive or use of immunosuppressive drugs (a letter of clearance from your physician is required)
- ☐ Multiple sclerosis (a letter of clearance from your physician is required with confirmation that the area to be treated is not numb)
- ☐ Immune disorders such as: Scleroderma, Lupus, Porphyria, Sarcoidosis and others
- ☐ Children under the age of 12
- ☐ Treatment over numbness of any body part
- ☐ Treatment over moles or lesions of any kind
- ☐ Treatment over tattoos, port wine stains, under the eyebrows, or any orifice
- ☐ Use of photosensitive medications may cause increased sensitivity to the devices
- ☐ Bleeding problems or use of blood thinners

Client ~~Initial~~ AM

10. Tanning during the course of my laser treatments is not recommended and can cause a number of complications. My scheduled treatment may be postponed if I am too tan.

11. I should avoid all tanning and sun exposure for 4 weeks before and 1 week after each treatment, as well as avoiding tanning beds.

12. I have been informed to use a sunblock with an SPF of 30 or higher on the treated area during the course of laser treatments.

13. It is my responsibility to inform the center if my skin is any darker than when I first started treatment.

14. It is my responsibility to inform the center of any medical or prescription changes.

American Laser Centers

LASER HAIR REMOVAL TREATMENT CONSENT FORM

An American Laser Centers Professional has explained to me the nature, goals, limitations and possible complications of this procedure and alternative forms of treatment. I have had the opportunity to ask questions about the procedure, its limitations and possible complications. These have been answered to my satisfaction.

I understand that all items contained herein apply to the following procedure(s): **Laser-Assisted Hair Removal** and **Intense Pulsed Light–Assisted Hair Removal.**

The purpose of this procedure is to diminish and remove hairs. This procedure may require one or more treatments and may not produce total permanent hair removal. Alternative methods are electrolysis, other laser-assisted hair removal technologies, various topical therapies and shaving.

I clearly understand the following:

1. The potential benefits of the proposed procedure(s).
2. The possible alternative procedure(s).
3. The probability of success of my selected procedure.
4. The goal of Laser Hair Removal, as in any cosmetic procedure, is improvement, not perfection.
5. There is no guarantee that the expected or anticipated results from the treatments will be achieved.
6. For best results, I have been informed that multiple treatments are needed. More treatments may be needed depending on skin type, previous methods of hair removal and hair color.
7. I must avoid tweezing, waxing, threading and bleaching treatment areas.
8. Hormonal imbalance, pregnancy and menopause can affect treatment outcomes.

15. Post-treatment care is very important and I will adhere to all the instructions given to me. Improper care to the treated area may increase the chances of any complications.

16. Laser Hair Removal can permanently reduce the numbers of hairs growing in the treated areas. Any remaining hair in general will be thinner and more easily treated by alternative methods.

17. The risks of this procedure include pain, infection, scarring, drug reactions or interactions or unforeseen complications. There is also a risk of mismatch in the color or the texture of the skin, temporary redness, hive-like reaction or bruising, brownish skin discoloration, activation of fever blisters (herpes), temporary increased susceptibility to sunburn and persistent pinkness for months.

18. There is a possibility that this procedure will be unsuccessful, need to be repeated, or may require additional treatment of complications.

19. Tattooed "permanent" make up in the area to be treated with laser hair removal may darken, and there may be lightening of decorative tattoos.

20. I authorize the taking of photographs or videotapes, or other similar means of recording the treatment. I understand that these recordings may be used for publication, medical study, demonstration research and documentation of progress in my medical record. Failure to allow the taking of photographs of my treatment areas will make it impossible to judge the efficacy of my treatments and will void any extended treatment program, guaranty and/or any treatment due beyond those included in the purchased package.

21. I have been given copies of both pre and post care instructions.

22. I understand the procedure and accept the risks, and request that this procedure be performed by a provider at American Laser Centers.

23. I have had sufficient opportunity to discuss my condition and treatment with the American Laser Centers professional, and all my questions have been answered to my satisfaction. I believe I have adequate knowledge to understand the nature and risk of the treatment to which I am consenting.

24. A partial refund will be provided for consumers who have had their appointment rescheduled for the same treatment session more than once. This only applies in the situation where the rescheduling is at the request of the clinic, not the consumer. The refund will consist of the total package price minus the value of treatments already received. Additional refunds may be granted on a case by case basis.

I have read and understand all information presented to me before signing this consent form. I have had ample opportunity to ask any questions regarding laser hair removal, side effects and after care.

Client/Guardian Signature _____ Date 12-5-09

Staff Signature _____ Date 12-5-09

American Laser Centers

Pre/Post Instructions for Laser Hair Removal

No waxing, tweezing, coloring or depilatories on the treatment area during the entire course of your treatments. Shaving or clipping is permitted as often as desired.

- Use your AmeriPure Laser Lotion 3-4 times a day until all pinkness has subsided.
- Shave the treatment area the day of your treatment unless instructed otherwise. If you cannot shave, we will shave the area for you at an additional $35 charge.
- No direct sun tanning or tanning bed or booth usage or artifical tanning product usage 3-4 weeks before treatment and 1 week after your treatment.
- Do not use on areas of Hair Removal: AmeriPure Cell Turnover, AmeriPure Anti Oil, AmeriPure Skin Lightener, any exfoliation products, Retin A, topical antibiotic, topical acne preparation, topical rosacea preparation, glycolic, amino acid or bleaching creams 2 days before and 2-4 days after treatment or until all pinkness has subsided.
- If you have elected to use topical anesthetic, apply it to skin in accordance with the product instructions 30 minutes before your scheduled appointment. The topical is called Elamax and can be purchased without prescription.
- Do not apply any creams or lotions on the area to be treated the day of treatment except for the face, which is easy to wash. Remove all creams, lotions, skin care products and all makeup prior to any treatment.
- Use AmeriPure SPF 65 sun block every 2 hours when exposed to the sun during the course of treatments.
- You may experience a slight sunburn or razor burn feeling after a treatment. Though rare, a fine crust may develop in certain sensitive areas. In either instance, you may apply a cool compress along with your post laser cream 3-4 times a day until resolved. This may last 1-3 days.
- Washing is permitted with a mild soap and tepid water. Never use hot water on freshly treated areas.
- The hairs from treated follicles will gradually work themselves out. Please do not pick, rub or scratch. This process can take up to 3-4 weeks.
- In any instance that the skin should blister or breaks open, you must call our office so that we can arrange for an evaluation by our staff.
- If itching occurs, a cortisone cream may be applied three times a day.
- If you must cancel or reschedule your appointment, please contact the office at least 48 hours in advance. Otherwise, a $35 cancellation fee may be applied, due to the high demand for treatment time.

If you have any questions or concerns, please contact us as soon as possible. We look forward to seeing you at your next appointment. Phone #: 267 376-

I have read and understand the above instructions. In order to obtain the best results, I must follow these instructions diligently. Failure to follow these instructions may void my guarantee.

Client Signature: _____ Date: 12/5/05

Staff Signature: _____ Date: 12/5/05

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health/personal information (PHI) to carryout out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes our rights to access and control your protected information. "Protected health/personal information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health/Personal Information

Uses and Disclosures of Protected Health/Personal Information
Your protected health/personal information may be used and disclosed by our medical director, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to support business operations of this office, if requested by you to a finance company to pay for your care, and any other use required by law.

Treatment: We will use and disclose your protected health/personal information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health/personal information, as necessary, if, as a result of our services, you require treatment by a physician. Your protected health/personal information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health/personal information will be used, if requested, to obtain payment for your services. For example, if you desire to finance the costs of your treatments, this may involve disclosing relevant protected private information in order to obtain approval.

Healthcare Operations: We may use or disclose, as needed, your protected health/personal information in order to support the business activities of this office. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to see you. We may use or disclose your protected health/personal information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health/personal information in the following situations without your authorization. These situations include: as required by law; public health issues as required by law, communicable diseases; health oversight; abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; coroners, funeral directors and organ donation; research; criminal activity and national security; workers' compensation; inmates; required uses and disclosures. Under the law, we must make disclosure to you and, when required by the Secretary of the U.S. Department of Health and Human Services, to investigate or determine our compliance with the requirements of the Standards for Privacy of Individually Identifiable Health Information set forth at 45 C.F.R. parts 160 and 164.

Other Permitted and Required Uses and Disclosures will be made only with your written authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that this office has taken an action in reliance on the use or disclosure indicated in the authorization.

Patient initials

1. **Your Rights**

Following is a statement of your rights with respect to your protected health/personal information.

You have the right to inspect and copy your protected health/personal information. Under federal law, however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health/personal information that is subject to law that prohibits access to protected health/personal information.

You have the right to require a restriction of your protected health/personal information. This means you may ask us not to use or disclose any part of your protected health/personal information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health/personal information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

We are not required to agree to a restriction that you may request. If our medical director believes it is in your best interest to permit use and disclosure of your protected health/personal information, your protected health/personal information will not be restricted. You then have the right to use another service provider.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to amend your protected health/personal information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to our statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health/personal information.

We reserve the right to change the terms of this notice and make the new notice provisions effective for all protected health information we maintain. We will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. We are also required by law to abide by the terms of the notice currently in effect. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number, (248) 426-8250.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: [illegible] Signature: [illegible] Date: 12-5-09

American Laser Centers

Customer Receipt

Date of Sale: 05-Dec-09
1650904359625

Thank you for visiting American Laser Center. This is your receipt. Please retain for your records.

Patient Information
Maiellen Mayson
300 Parshian Rd Apt AX 13
phila, pa 19040

Clinic Information
American Laser Centers
582 Middletown Blvd.
Suite B-22
Langhorne, PA 19047
(267) 276-0006 (phone)
langhorne@americanlaser.com

Billing Information

Treatment(s)	Price
Lip Upper	$600.00
Chin	$1,560.00
Neck (Front)	$1,920.00
Face Sideburns	$1,200.00
Procedure Tax (0%)	$0.00
Discount(s):	($3,168.00)
Total:	**$2,112.00**

Payment Information

Method Of Payment	
Visa	$211.20
Amount Paid:	$211.20
Total Due	**$1,900.80**

I fully understand and agree to the treatment areas that will be treated. If no services are performed under this agreement, a refund will be issued at customer's written request minus a ten percent administrative fee. Otherwise, all fees are nonrefundable. Guarantee for hair removal package takes effect on the day the sixth treatment is completed.

American Laser Centers

Customer Receipt

Date of Sale: 07-Jun-10
1651005057975

Thank you for visiting American Laser Center. This is your receipt. Please retain for your records.

Patient Information
Maiellen Mayson
300 Parshian Rd Apt AX 13
phila, pa 19040

Clinic Information
American Laser Centers
582 Middletown Blvd.
Suite B-22
Langhorne, PA 19047
(267) 276-0006 (phone)
langhorne@americanlaser.com

Previous Patient Balance	$1,900.80
Advert Coupons	($0.00)
Total:	**$1,900.80**

Payment Information

Method Of Payment	
Cash	$400.00
Amount Paid:	$400.00
Total Due	**$1,500.80**

I fully understand and agree to the treatment areas that will be treated. If no services are performed under this agreement, a refund will be issued at customer's written request minus a ten percent administrative fee. Otherwise, all fees are nonrefundable. Guarantee for hair removal package takes effect on the day the sixth treatment is completed.

American Laser Centers

Customer Receipt

Date of Sale: 02-Jul-10
1651005156413

Thank you for visiting American Laser Center. This is your receipt. Please retain for your records.

Patient Information
Maiellen Mayson
300 Parshian Rd Apt AX 13
phila, pa 19040

Clinic Information
American Laser Centers
582 Middletown Blvd.
Suite B-22
Langhorne, PA 19047
(267) 276-0006 (phone)
langhorne@americanlaser.com

Previous Patient Balance	$1,500.80
Advert Coupons	($0.00)
Total:	**$1,500.80**

Payment Information

Method Of Payment	
Cash	$100.00
Amount Paid:	$100.00
Total Due	**$1,400.80**

I fully understand and agree to the treatment areas that will be treated. If no services are performed under this agreement, a refund will be issued at customer's written request minus a ten percent administrative fee. Otherwise, all fees are nonrefundable. Guarantee for hair removal package takes effect on the day the sixth treatment is completed.

ALL CHARTS for a Patient

Maiellen Mayson (Patient ID 1039641) Chart number 10396415965726. Chart completed on 06/07/2010 for treatment at the Langhorne clinic.

Action:

[Return To Client Charting]

Patient Chart ID 10396415965726 History

Chart ID #: 10396415965726
Date Created: 2010-06-07 19:59:47.513

Transactions Processed

Date Actioned	Action Taken	Actioned By
2010-06-07 19:59:44.397	Verified Hipaa/Consent Forms Signed	alcpa166
2010-06-07 19:59:47.503	Step 1 Completed	alcpa166
2010-06-07 19:59:47.513	Chart Created	alcpa166
2010-06-07 20:00:00.6	Step 2 Completed	alcpa166
2010-06-07 20:00:00.6	Skin Type Assessment Submited	alcpa166
2010-06-07 20:21:35.44	Step 3 Completed	alcpa166
2010-06-07 20:21:35.443	Treatment Record Q1 Completed	alcpa166
2010-06-07 20:38:23.293	Step 4 Completed	alcpa166
2010-06-07 20:38:23.293	Treatment Record Q2 Completed	alcpa166
2010-06-07 20:38:44.793	Chart Laser Test Settings Submitted	alcpa166
2010-06-07 20:39:04.527	Step 5 Completed	alcpa166
2010-06-07 20:39:04.537	Treatment Record Settings Completed	alcpa166

Maiellen Mayson (Patient ID 1039641) Chart number 10396415965726. Chart completed on 06/07/2010 for treatment at the Langhorne clinic.

Step 1:

American Laser Centers Intranet

Friday, August 06, 2010

ALCPartner Scheduler Application 1
Welcome afrench: [Logout]

Announcements | Scheduler v | Database v | Accounting v | HR v | ALC Learning v | Marketing v | Call Center v | Ameripure v | Email
Applications v | SiteMap

QUICK LINKS >> Click Here To Select v

① - ② - ③ - ④ - ⑤

Create Chart For Patient

Procedures

Select Procedure(s) for Chart:
Chin

* Please select the procedure that will be treated in this chart.

Update Chart Procedure

Maiellen Mayson (Patient ID 1039641) Chart number 10396415965726. Chart completed on 06/07/2010 for treatment at the Langhorne clinic.

Step 2:

American Laser Centers Intranet

Friday, August 06, 2010

ALCPartner Scheduler Application 1
Welcome afrench: [Logout]

Announcements | Scheduler v | Database v | Accounting v | HR v | ALC Learning v | Marketing v | Call Center v | Ameripure v | Email | Applications v | SiteMap

QUICK LINKS >> Click Here To Select v

Skin Type Assessment Form

① - ② - ③ - ④ - ⑤

Please verify the questions highlighted in this color are correct before proceeding.

Genetic Disposition

1. What is the color of your eyes?
○ Light Blue, Green ○ Gray ○ Blue ⊙ Dark Brown ○ Brown/Black

2. What is your natural hair color?
○ Sandy Red ○ Blonde ○ Chestnut/Dark Blonde ⊙ Dark Brown ○ Black

3. What is the color of your skin?
○ Reddish ○ Very Pale ○ Pale ⊙ Light Brown ○ Dark Brown

4. Do you have freckles?
○ Many ○ Several ○ Few ⊙ Incidental ○ None

Reaction to Sun Exposure

1. If you where over exposed to the sun how would your skin react?
○ Redness/Blistering/Peels ○ Blistering/Peeling ○ Burns Sometimes/Peels ⊙ Rarely Burns ○ Never Burns

2. To what degree does your skin turn brown?
○ Hardly/Not At All ○ Light Color Tan ○ Medium Tan ⊙ Tans Easily ○ Turns Dark Brown Quickly

3. Do you turn brown within several hours after sun exposure?
○ Never ○ Seldom ○ Sometimes ⊙ Often ○ Always

4. How does your face react to the sun?
○ Very Sensitive ○ Sensitive ○ Normal ⊙ Very Resistant ○ No Problem

Tanning Habits

1. When was your last exposure to sun, lamps or cream?
○ More Than 3 Months ○ 2 to 3 Months ⊙ 1 to 2 Months ○ Less Than 1 Month ○ Less Than 2 Weeks

2. Was the treatment area exposed?
○ Never ○ Hardly Ever ○ Sometimes ○ Often ⊙ Always

Heritage

If Father is of African American or East Indian descent add	☑ 10 Points
If Mother is of African American or East Indian descent add	☑ 10 Points
If Latin American, Asian-Pacific Islanders, Mediteranean, or native or indigenous to the Americas add	☐ 5 Points

Summary

Total Score
Skin Type Score 50

Update Assessment

Skin Type Score		Skin Type
0 to 8	-	I
9 to 16	-	II
17 to 24	-	III
25 to 30	-	IV
31 to 34	-	V

Maiellen Mayson (Patient ID 1039641) Chart number 10396415965726. Chart completed on 06/07/2010 for treatment at the Langhorne clinic.

Step 3:

American Laser Centers Intranet

Friday, August 06, 2010

ALCPartner Scheduler Application 1
Welcome afrench: [Logout]

Announcements | Scheduler v | Database v | Accounting v | HR v | ALC Learning v | Marketing v | Call Center v | Ameripure v | Email
Applications v | SiteMap

QUICK LINKS >> Click Here To Select v

① - ② - ③ - ④ - ⑤

Treatment Record Questionnaire 1

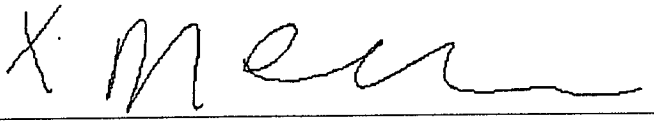
Patient Information	
Patient Name:	Maiellen Mayson
Treatment Area:	Chin
Treatment Number:	1
Skin Type:	VI

Please verify the questions highlighted in this color are correct before proceeding.

Please fill out questions 1-10

1. Have you been diagnosed with diabetes, lupus, sarcoidosis, cancer, skin disorder, seizure disorder, numbness in the area to be treated, HIV positive or multiple sclerosis?* ○ Yes ⊙ No
   If YES, please specify: N/A
2. Do you have a pacemaker or any internal metal device?* ○ Yes ⊙ No
   If YES, please specify: N/A
3. Are you or do you think you may be pregnant?* ○ Yes ⊙ No
4. Have you ever had a cold sore in treatment area?* ○ Yes ⊙ No
   If YES, do you have Valtrex at home? ○ Yes ⊙ No
5. Please list all medications, even those over-the-counter medications and medicinal herbs you take:
   N/A
6. Are you tan?* ○ Yes ⊙ No
   When was your last sun exposure, self-tanning lotions applied, and/or tanning booth exposure to the area we will treat today?*
   1 day
7. Are you on Accutane?* ○ Yes ⊙ No
8. Have you had any hormonal changes including menopause?* ○ Yes ⊙ No
   If YES, please specify: N/A
9. Are you on chemo or radiation therapy?* ○ Yes ⊙ No
   If YES, please specify: N/A
10. Do you have vitiligo or a history of vitiligo?* ○ Yes ⊙ No

Date: **Signature:**

06/07/2010 

Update Questionnaire ---->

* These Are Required Fields

Maiellen Mayson (Patient ID 1039641) Chart number 10396415965726. Chart completed on 06/07/2010 for treatment at the Langhorne clinic.

Step 4:

Treatment Record Questionnaire 2

Patient Information	
Patient Name:	Maiellen Mayson
Treatment Area:	Chin
Treatment Number:	1
Skin Type:	VI

Please fill out questions 1-8

1. Is patient on AmeriPure Skin Care?* ○ Yes ⊙ No If no, then introduce products to your patient.
2. Have photos been taken?* ⊙ Yes ○ No (Take before all treatments)
3. Is patient tan BY YOUR ASSESSMENT?* ○ Yes ⊙ No
   Date of last exposure: 1 Days
4. Client comments on hair reduction: 0 - 9% None
5. How long did patient stay pink?* 0 - 10 Mins
   Any concerns from last treatment?
   N/A
6. Did patient use topical anesthetic cream?* ○ Yes ⊙ No If yes, wipe off with water thoroughly.
7. Does the patient have keloid scarring?* ○ Yes ⊙ No

Update Questionnaire 2 --->

* These Are Required Fields

Maiellen Mayson (Patient ID 1039641) Chart number 10396415965726. Chart completed on 06/07/2010 for treatment at the Langhorne clinic.

Step 5:

American Laser Centers Intranet

Friday, August 06, 2010

ALCPartner Scheduler Application 1
Welcome afrench: [Logout]

Announcements | Scheduler v | Database v | Accounting v | HR v | ALC Learning v | Marketing v | Call Center v | Ameripure v | Email | Applications v | SiteMap

QUICK LINKS >> Click Here To Select v

① - ② - ③ - ④ - ⑤

Treatment Record Laser Settings

Client Information	
Client Name:	Maiellen Mayson
DOB:	80
Center Name:	Langhorne
Technician: (Employee ID)	1754

Laser Hair Removal Chart	
Skin Type:	VI
Hair Color:	Dark Brown
Treatment Area:	Chin
Is Client Tan?:	NO

Laser for Procedure
Laser Selected: Aurora/Amerilight (NEW)

Laser Test Area

ID	Test Area
10396415965726	Face - Left forehead or behind ears

Laser Test Settings

#	ID	Date	Skin Type	RF	OF	P Type	ISL	ISM	Laser
1	10396415965726	06/07/2010	VI	F 25 T 25	F 12 T 10	Long	15	F 13 T 10	Aurora/Amerilight (NEW)

Laser Hair Removal Chart Settings

#	ID	Date	Skin Type	RF	OF	P Type	ISL	ISM	Laser
1	10396415965726	06/07/2010	VI	24	10	Long	15	7 - 10	Aurora/Amerilight (NEW)

Notes

Answer Questions 1-5

1. Was client double passed? ○ Yes ◉ No
1a. Was skin type changed (if skin type I - III)? ○ Yes ◉ No
2. Was ice pack applied? ◉ Yes ○ No
3. Post Treatment skin reaction?
4. AmeriPure Post Treatment Lotion applied? ◉ Yes ○ No
4a. AmeriPure sun block applied? ○ Yes ◉ No
5. Post Instructions have been given verbally and written-on first treatment? ◉ Yes ○ No

I verify that this form is complete and correct.

Date: 06/07/2010 **Staff Signature:** SJS

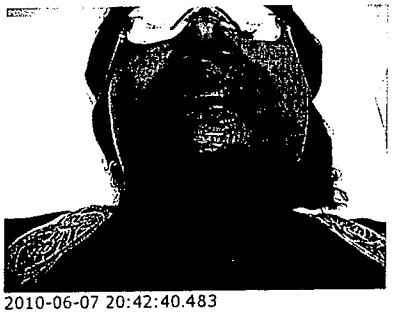
Update Chart

Maiellen Mayson (Patient ID 1039641) Chart number 10396415965726. Chart completed on 06/07/2010 for treatment at the Langhorne clinic.

Step 6/Photos:
Chart # 10396415965726 Photos

Maiellen Mayson

[Close Window]



2010-06-07 20:42:40.483

Maiellen Mayson (Patient ID 1039641) Chart number 10396416103576. Chart completed on 07/02/2010 for treatment at the Langhorne clinic.

Action:

[Return To Client Charting]

Patient Chart ID 10396416103576 History

Chart ID #: 10396416103576

Date Created: 2010-07-02 19:53:13.377

Transactions Processed

Date Actioned	Action Taken	Actioned By
2010-07-02 19:53:10.693	Verified Hipaa/Consent Forms Signed	alcpa166
2010-07-02 19:53:13.373	Step 1 Completed	alcpa166
2010-07-02 19:53:13.377	Chart Created	alcpa166
2010-07-02 20:10:50.643	Step 2 Completed	alcpa166
2010-07-02 20:10:50.65	Skin Type Assessment Submited	alcpa166
2010-07-02 20:11:14.477	Step 3 Completed	alcpa166
2010-07-02 20:11:14.49	Treatment Record Q1 Completed	alcpa166
2010-07-02 20:22:21.75	Step 4 Completed	alcpa166
2010-07-02 20:22:21.75	Treatment Record Q2 Completed	alcpa166
2010-07-02 20:22:43.697	Chart Laser Test Settings Submitted	alcpa166
2010-07-02 20:23:07.877	Step 5 Completed	alcpa166
2010-07-02 20:23:07.88	Treatment Record Settings Completed	alcpa166

Maiellen Mayson (Patient ID 1039641) Chart number 10396416103576. Chart completed on 07/02/2010 for treatment at the Langhorne clinic.

Step 1:

American Laser Centers Intranet

Friday, August 06, 2010

ALCPartner Scheduler Application 1
Welcome afrench: [Logout]

Announcements | Scheduler v | Database v | Accounting v | HR v | ALC Learning v | Marketing v | Call Center v | Ameripure v | Email
Applications v | SiteMap

QUICK LINKS >> Click Here To Select v

Create Chart For Patient

① - ② - ③ - ④ - ⑤

Procedures

Select Procedure(s) for Chart:
Chin

* Please select the procedure that will be treated in this chart.

Update Chart Procedure

Maiellen Mayson (Patient ID 1039641) Chart number 10396416103576. Chart completed on 07/02/2010 for treatment at the Langhorne clinic.

Step 2:

American Laser Centers Intranet

Friday, August 06, 2010

ALCPartner Scheduler Application 1
Welcome afrench: [Logout]

Announcements | Scheduler v | Database v | Accounting v | HR v | ALC Learning v | Marketing v | Call Center v | Ameripure v | Email
Applications v | SiteMap

QUICK LINKS >> Click Here To Select v

Skin Type Assessment Form

① - ② - ③ - ④ - ⑤

Please verify the questions highlighted in this color are correct before proceeding.

Genetic Disposition

1. What is the color of your eyes?
○ Light Blue, Green ○ Gray ○ Blue ⊙ Dark Brown ○ Brown/Black

2. What is your natural hair color?
○ Sandy Red ○ Blonde ○ Chestnut/Dark Blonde ⊙ Dark Brown ○ Black

3. What is the color of your skin?
○ Reddish ○ Very Pale ○ Pale ⊙ Light Brown ○ Dark Brown

4. Do you have freckles?
○ Many ○ Several ○ Few ⊙ Incidental ○ None

Reaction to Sun Exposure

1. If you where over exposed to the sun how would your skin react?
○ Redness/Blistering/Peels ○ Blistering/Peeling ○ Burns Sometimes/Peels ⊙ Rarely Burns ○ Never Burns

2. To what degree does your skin turn brown?
○ Hardly/Not At All ○ Light Color Tan ○ Medium Tan ⊙ Tans Easily ○ Turns Dark Brown Quickly

3. Do you turn brown within several hours after sun exposure?
○ Never ○ Seldom ○ Sometimes ⊙ Often ○ Always

4. How does your face react to the sun?
○ Very Sensitive ○ Sensitive ○ Normal ⊙ Very Resistant ○ No Problem

Tanning Habits

1. When was your last exposure to sun, lamps or cream?
○ More Than 3 Months ○ 2 to 3 Months ⊙ 1 to 2 Months ○ Less Than 1 Month ○ Less Than 2 Weeks

2. Was the treatment area exposed?
○ Never ○ Hardly Ever ○ Sometimes ○ Often ⊙ Always

Heritage

If Father is of African American or East Indian descent add	☑ 10 Points
If Mother is of African American or East Indian descent add	☑ 10 Points
If Latin American, Asian-Pacific Islanders, Mediteranean, or native or indigenous to the Americas add	☐ 5 Points

Summary

Total Score	
Skin Type Score	50

Update Assessment

Skin Type Score		Skin Type
0 to 8	-	I
9 to 16	-	II
17 to 24	-	III
25 to 30	-	IV
31 to 34	-	V

Maiellen Mayson (Patient ID 1039641) Chart number 10396416103576. Chart completed on 07/02/2010 for treatment at the Langhorne clinic.

Step 3:

American Laser Centers Intranet

Friday, August 06, 2010

ALCPartner Scheduler Application 1
Welcome afrench: [Logout]

Announcements | Scheduler v | Database v | Accounting v | HR v | ALC Learning v | Marketing v | Call Center v | Ameripure v | Email | Applications v | SiteMap

QUICK LINKS >> Click Here To Select v

① - ② - ③ - ④ - ⑤

Treatment Record Questionnaire 1

Patient Information	
Patient Name:	Maiellen Mayson
Treatment Area:	Chin
Treatment Number:	2
Skin Type:	VI

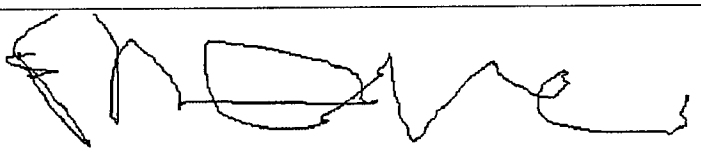
Please verify the questions highlighted in this color are correct before proceeding.

Please fill out questions 1-10

1. Have you been diagnosed with diabetes, lupus, sarcoidosis, cancer, skin disorder, seizure disorder, numbness in the area to be treated, HIV positive or multiple sclerosis?* ○ Yes ⊙ No
   If YES, please specify: N/A
2. Do you have a pacemaker or any internal metal device?* ○ Yes ⊙ No
   If YES, please specify: N/A
3. Are you or do you think you may be pregnant?* ○ Yes ⊙ No
4. Have you ever had a cold sore in treatment area?* ○ Yes ⊙ No
   If YES, do you have Valtrex at home? ○ Yes ⊙ No
5. Please list all medications, even those over-the-counter medications and medicinal herbs you take:
   N/A
6. Are you tan?* ○ Yes ⊙ No
   When was your last sun exposure, self-tanning lotions applied, and/or tanning booth exposure to the area we will treat today?*
   1 day
7. Are you on Accutane?* ○ Yes ⊙ No
8. Have you had any hormonal changes including menopause?* ○ Yes ⊙ No
   If YES, please specify: N/A
9. Are you on chemo or radiation therapy?* ○ Yes ⊙ No
   If YES, please specify: N/A
10. Do you have vitiligo or a history of vitiligo?* ○ Yes ⊙ No

Date: **Signature:**

07/02/2010



Update Questionnaire ---->

* These Are Required Fields

Maiellen Mayson (Patient ID 1039641) Chart number 10396416103576. Chart completed on 07/02/2010 for treatment at the Langhorne clinic.

Step 4:

American Laser Centers Intranet

Friday, August 06, 2010

ALCPartner Scheduler Application 1
Welcome afrench: [Logout]

Announcements | Scheduler v | Database v | Accounting v | HR v | ALC Learning v | Marketing v | Call Center v | Ameripure v | Email | Applications v | SiteMap

QUICK LINKS >> Click Here To Select v

Treatment Record Questionnaire 2

① - ② - ③ - ④ - ⑤

Patient Information	
Patient Name:	Maiellen Mayson
Treatment Area:	Chin
Treatment Number:	1
Skin Type:	VI

Please fill out questions 1-8

1. Is patient on AmeriPure Skin Care?* (•) Yes ( ) No If no, then introduce products to your patient.
2. Have photos been taken?* (•) Yes ( ) No (Take before all treatments)
3. Is patient tan BY YOUR ASSESSMENT?* ( ) Yes (•) No
   Date of last exposure: More Than A Month
4. Client comments on hair reduction: 0 - 9% None
5. How long did patient stay pink?* 0 - 10 Mins
   Any concerns from last treatment?
   none
6. Did patient use topical anesthetic cream?* ( ) Yes (•) No If yes, wipe off with water thoroughly.
7. Does the patient have keloid scarring?* ( ) Yes (•) No

Update Questionnaire 2 --->

* These Are Required Fields

Maiellen Mayson (Patient ID 1039641) Chart number 10396416103576. Chart completed on 07/02/2010 for treatment at the Langhorne clinic.

Step 5:

American Laser Centers Intranet

Friday, August 06, 2010

ALCPartner Scheduler Application 1
Welcome afrench: [Logout]

Announcements | Scheduler v | Database v | Accounting v | HR v | ALC Learning v | Marketing v | Call Center v | Ameripure v | Email | Applications v | SiteMap

QUICK LINKS >> Click Here To Select v

Treatment Record Laser Settings

① - ② - ③ - ④ - ⑤

Client Information	
Client Name:	Maiellen Mayson
DOB:	:80
Center Name:	Langhorne
Technician: (Employee ID)	943022

Laser Hair Removal Chart	
Skin Type:	VI
Hair Color:	Dark Brown
Treatment Area:	Chin
Is Client Tan?:	NO

Laser for Procedure
Laser Selected: Aurora/Amerilight (NEW)

Laser Test Area

ID	Test Area
10396415965726	Face - Left forehead or behind ears

Laser Test Settings

#	ID	Date	Skin Type	RF	OF	P Type	ISL	ISM	Laser
2	10396416103576	07/02/2010	VI	F 25 T 25	F 12 T 12	Long	15	F 2 T 12	Aurora/Amerilight (NEW)

Laser Hair Removal Chart Settings

#	ID	Date	Skin Type	RF	OF	P Type	ISL	ISM	Laser
2	10396416103576	07/02/2010	VI	25	12	Long	15	2 - 12	Aurora/Amerilight (NEW)

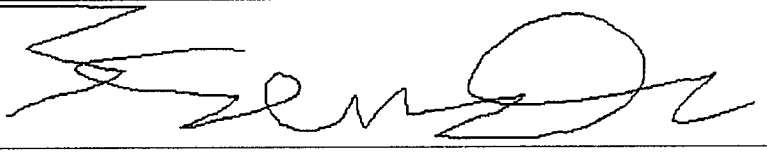
Notes

Answer Questions 1-5

1. Was client double passed? ○ Yes ◉ No
1a. Was skin type changed (if skin type I - III)? ○ Yes ◉ No
2. Was ice pack applied? ◉ Yes ○ No
3. Post Treatment skin reaction?
none
4. AmeriPure Post Treatment Lotion applied? ◉ Yes ○ No
4a. AmeriPure sun block applied? ◉ Yes ○ No
5. Post Instructions have been given verbally and written-on first treatment? ◉ Yes ○ No

I verify that this form is complete and correct.

Date: 07/02/2010 **Staff Signature:**



Update Chart

Maiellen Mayson (Patient ID 1039641) Chart number 10396416103576. Chart completed on 07/02/2010 for treatment at the Langhorne clinic.

Step 6/Photos:
Chart # 10396416103576 Photos

Maiellen Mayson

[Close Window]

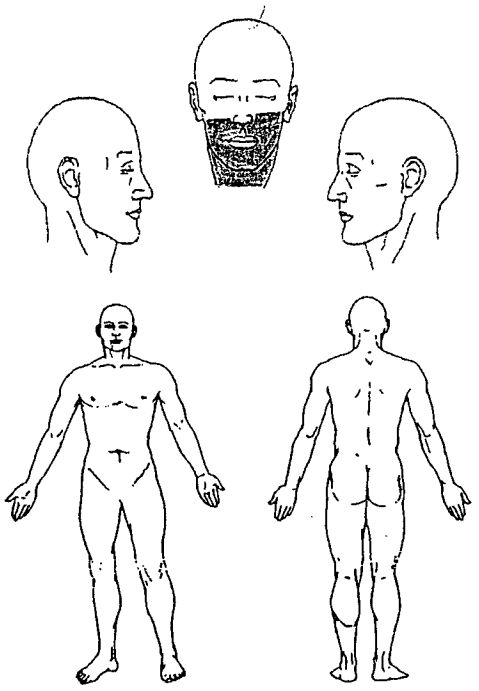
2010-07-02 20:26:30.623

American Laser Centers Treatment and Financial Agreement

Client Name: Mai-Phi Mayson Date: 12-5-09

Notes: _____

Treatment Area	Price	Discount	Price	Product	Price
[illegible]	1560	1/2			
[illegible]	1560	-60%			
[illegible]	[illegible]				
[illegible]	[illegible]				
Total	2412 00	Total		Tax	
				Total	



Hair Removal
- ❑ Per Treatment - **Price Subject to Change** (Initial _____)
- ❑ Paid in Full - Package of 6 with 2 Year Guarantee

FotoFacial
- ❑ Per Treatment - **Price Subject to Change** (Initial _____)
- ❑ Paid in Full - Package of 5 FotoFacials/5 Microdermabrasions

Skin Tightening
- ❑ Per Treatment - **Price Subject to Change** (Initial _____)
- ❑ Paid in Full - Package of _____ treatments

Affirm
- ❑ Per Treatment - **Price Subject to Change** (Initial _____)
- ❑ Paid in Full - Package of _____ treatments

Microdermabrasion
- ❑ Per Treatment - **Price Subject to Change** (Initial _____)
- ❑ Paid in Full - Package of _____ treatments

AmeriSmooth
- ❑ Per Treatment - **Price Subject to Change** (Initial _____)
- ❑ Paid in Full - Package of _____ treatments

Total Treatment Price $_____

Total Product Price $_____

Total Sales Price $ 2412.00

I fully understand and agree to the treatment areas that will be treated. If no services are performed under this agreement, a refund will be issued at customer's written request minus a ten percent administrative fee. Otherwise, all fees are nonrefundable. Guarantee for hair removal package takes effect on the day the sixth treatment is completed.

Client Signature: _____ Date: 12/5/09

Staff Signature: _____ Date: 12/5/09

American Laser Centers

Hair Removal & Skin Rejuvenation

LASER HAIR REMOVAL TREATMENT CONSENT FORM

An American Laser Centers Professional has explained to me the nature, goals, limitations and possible complications of this procedure and alternative forms of treatment. I have had the opportunity to ask questions about the procedure, its limitations and possible complications. These have been answered to my satisfaction.

I understand that all items contained herein apply to the following procedure(s): **Laser-Assisted Hair Removal** and **Intense Pulsed Light–Assisted Hair Removal.**

The purpose of this procedure is to diminish and remove hairs. This procedure may require one or more treatments and may not produce total permanent hair removal. Alternative methods are electrolysis, other laser-assisted hair removal technologies, various topical therapies and shaving.

I clearly understand the following:

1. The potential benefits of the proposed procedure(s).
2. The possible alternative procedure(s).
3. The probability of success of my selected procedure.
4. The goal of Laser Hair Removal, as in any cosmetic procedure, is improvement, not perfection.
5. There is no guarantee that the expected or anticipated results from the treatments will be achieved.
6. For best results, I have been informed that multiple treatments are needed. More treatments may be needed depending on skin type, previous methods of hair removal and hair color.
7. I must avoid tweezing, waxing, threading and bleaching treatment areas.
8. Hormonal imbalance, pregnancy and menopause can affect treatment outcomes.

9. Contraindications for this procedure include:

- ☐ Pregnancy and nursing
- ☐ Accutane (must discontinue use of product 3 months before beginning treatment)
- ☐ Epilepsy or those who have a history of seizures
- ☐ Diabetes (no treatment below the ankles and no shaving)
- ☐ Poorly controlled Diabetes
- ☐ Current history of skin cancer, or current condition of any other type of cancer, or pre-malignant moles in area of treatment
- ☐ Active sores or rash (psoriasis, eczema) in the area to be treated
- ☐ Skin disorders such as keloids or abnormal wound healing
- ☐ History of melanoma anywhere on the body
- ☐ Recent (within 3 months) surgery, laser resurfacing or deep chemical peels in treatment area
- ☐ Severe medical disorders such as poorly controlled heart conditions
- ☐ Chemo or radiation therapy (letter of clearance from your physician is required)
- ☐ Pacemaker, internal defibrillator and any internal electrical devices
- ☐ Any internal metal device, i.e. surgical screws, pins, plates, or implants, in the area to be treated (no treatment if the device is superficially in the body area to be treated)
- ☐ AIDS, HIV positive or use of immunosuppressive drugs (a letter of clearance from your physician is required)
- ☐ Multiple sclerosis (a letter of clearance from your physician is required with confirmation that the area to be treated is not numb)
- ☐ Immune disorders such as: Scleroderma, Lupus, Porphyria, Sarcoidosis and others
- ☐ Children under the age of 12
- ☐ Treatment over numbness of any body part
- ☐ Treatment over moles or lesions of any kind
- ☐ Treatment over tattoos, port wine stains, under the eyebrows, or any orifice
- ☐ Use of photosensitive medications may cause increased sensitivity to the devices
- ☐ Bleeding problems or use of blood thinners

Client Initial ~~_____~~

10. Tanning during the course of my laser treatments is not recommended and can cause a number of complications. My scheduled treatment may be postponed if I am too tan.

11. I should avoid all tanning and sun exposure for 4 weeks before and 1 week after each treatment, as well as avoiding tanning beds.

12. I have been informed to use a sunblock with an SPF of 30 or higher on the treated area during the course of laser treatments.

13. It is my responsibility to inform the center if my skin is any darker than when I first started treatment.

14. It is my responsibility to inform the center of any medical or prescription changes.

15. Post-treatment care is very important and I will adhere to all the instructions given to me. Improper care to the treated area may increase the chances of any complications.

16. Laser Hair Removal can permanently reduce the numbers of hairs growing in the treated areas. Any remaining hair in general will be thinner and more easily treated by alternative methods.

17. The risks of this procedure include pain, infection, scarring, drug reactions or interactions or unforeseen complications. There is also a risk of mismatch in the color or the texture of the skin, temporary redness, hive-like reaction or bruising, brownish skin discoloration, activation of fever blisters (herpes), temporary increased susceptibility to sunburn and persistent pinkness for months.

18. There is a possibility that this procedure will be unsuccessful, need to be repeated, or may require additional treatment of complications.

19. Tattooed "permanent" make up in the area to be treated with laser hair removal may darken, and there may be lightening of decorative tattoos.

20. I authorize the taking of photographs or videotapes, or other similar means of recording the treatment. I understand that these recordings may be used for publication, medical study, demonstration research and documentation of progress in my medical record. Failure to allow the taking of photographs of my treatment areas will make it impossible to judge the efficacy of my treatments and will void any extended treatment program, guaranty and/or any treatment due beyond those included in the purchased package.

21. I have been given copies of both pre and post care instructions.

22. I understand the procedure and accept the risks, and request that this procedure be performed by a provider at American Laser Centers.

23. I have had sufficient opportunity to discuss my condition and treatment with the American Laser Centers professional, and all my questions have been answered to my satisfaction. I believe I have adequate knowledge to understand the nature and risk of the treatment to which I am consenting.

24. A partial refund will be provided for consumers who have had their appointment rescheduled for the same treatment session more than once. This only applies in the situation where the rescheduling is at the request of the clinic, not the consumer. The refund will consist of the total package price minus the value of treatments already received. Additional refunds may be granted on a case by case basis.

I have read and understand all information presented to me before signing this consent form. I have had ample opportunity to ask any questions regarding laser hair removal, side effects and after care.

Client/Guardian Signature _____ Date 12-5-09

Staff Signature _____ Date 12-5-09

American Laser Centers

Pre/Post Instructions for Laser Hair Removal

No waxing, tweezing, coloring or depilatories on the treatment area during the entire course of your treatments. Shaving or clipping is permitted as often as desired.

- Use your AmeriPure Laser Lotion 3-4 times a day until all pinkness has subsided.
- Shave the treatment area the day of your treatment unless instructed otherwise. If you cannot shave, we will shave the area for you at an additional $35 charge.
- No direct sun tanning or tanning bed or booth usage or artifical tanning product usage 3-4 weeks before treatment and 1 week after your treatment.
- Do not use on areas of Hair Removal: AmeriPure Cell Turnover, AmeriPure Anti Oil, AmeriPure Skin Lightener, any exfoliation products, Retin A, topical antibiotic, topical acne preparation, topical rosacea preparation, glycolic, amino acid or bleaching creams 2 days before and 2-4 days after treatment or until all pinkness has subsided.
- If you have elected to use topical anesthetic, apply it to skin in accordance with the product instructions 30 minutes before your scheduled appointment. The topical is called Elamax and can be purchased without prescription.
- Do not apply any creams or lotions on the area to be treated the day of treatment except for the face, which is easy to wash. Remove all creams, lotions, skin care products and all makeup prior to any treatment.
- Use AmeriPure SPF 65 sun block every 2 hours when exposed to the sun during the course of treatments.
- You may experience a slight sunburn or razor burn feeling after a treatment. Though rare, a fine crust may develop in certain sensitive areas. In either instance, you may apply a cool compress along with your post laser cream 3-4 times a day until resolved. This may last 1-3 days.
- Washing is permitted with a mild soap and tepid water. Never use hot water on freshly treated areas.
- The hairs from treated follicles will gradually work themselves out. Please do not pick, rub or scratch. This process can take up to 3-4 weeks.
- In any instance that the skin should blister or breaks open, you must call our office so that we can arrange for an evaluation by our staff.
- If itching occurs, a cortisone cream may be applied three times a day.
- If you must cancel or reschedule your appointment, please contact the office at least 48 hours in advance. Otherwise, a $35 cancellation fee may be applied, due to the high demand for treatment time.

If you have any questions or concerns, please contact us as soon as possible. We look forward to seeing you at your next appointment. Phone #: 267/376-2006

I have read and understand the above instructions. In order to obtain the best results, I must follow these instructions diligently. Failure to follow these instructions may void my guarantee.

Client Signature: _____ Date: 12/5/05

Staff Signature: _____ Date: 12/5/05

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health/personal information (PHI) to carryout out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes our rights to access and control your protected information. "Protected health/personal information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. **Uses and Disclosures of Protected Health/Personal Information**

Uses and Disclosures of Protected Health/Personal Information
Your protected health/personal information may be used and disclosed by our medical director, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to support business operations of this office, if requested by you to a finance company to pay for your care, and any other use required by law.

Treatment: We will use and disclose your protected health/personal information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health/personal information, as necessary, if, as a result of our services, you require treatment by a physician. Your protected health/personal information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health/personal information will be used, if requested, to obtain payment for your services. For example, if you desire to finance the costs of your treatments, this may involve disclosing relevant protected private information in order to obtain approval.

Healthcare Operations: We may use or disclose, as needed, your protected health/personal information in order to support the business activities of this office. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to see you. We may use or disclose your protected health/personal information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health/personal information in the following situations without your authorization. These situations include: as required by law; public health issues as required by law, communicable diseases; health oversight; abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; coroners, funeral directors and organ donation; research; criminal activity and national security; workers' compensation; inmates; required uses and disclosures. Under the law, we must make disclosure to you and, when required by the Secretary of the U.S. Department of Health and Human Services, to investigate or determine our compliance with the requirements of the Standards for Privacy of Individually Identifiable Health Information set forth at 45 C.F.R. parts 160 and 164.

Other Permitted and Required Uses and Disclosures will be made only with your written authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that this office has taken an action in reliance on the use or disclosure indicated in the authorization.

Patient initials

1. **Your Rights**

Following is a statement of your rights with respect to your protected health/personal information.

You have the right to inspect and copy your protected health/personal information. Under federal law, however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health/personal information that is subject to law that prohibits access to protected health/personal information.

You have the right to require a restriction of your protected health/personal information. This means you may ask us not to use or disclose any part of your protected health/personal information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health/personal information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

We are not required to agree to a restriction that you may request. If our medical director believes it is in your best interest to permit use and disclosure of your protected health/personal information, your protected health/personal information will not be restricted. You then have the right to use another service provider.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to amend your protected health/personal information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to our statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health/ personal information.

We reserve the right to change the terms of this notice and make the new notice provisions effective for all protected health information we maintain. We will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. We are also required by law to abide by the terms of the notice currently in effect. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number, (248) 426-8250.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: 12-5-07

St. Mary Medical Center

Name: Mayson, Maiellen
Age: 30Y DOB: 980
Gender: F Wt: 65.8 Kg Ht: 157 cm.
MedRec: 3303559
AcctNum: LP0309925865
Attending: PLG
Primary RN: NAM
Bed: ED 2-C 12

ST MARY MEDICAL CENTER
PRESCRIPTION

Date: Wed Jul 07, 2010 01:20
By: G.Larry Geisler, DO
For: Mayson, Maiellen
Date of Birth: 1980
Patient Address:
1405 VETERANS HWY
APT J3
BRISTOL, PA 19007

Rx: Vicodin : Tablet : 500 mg-5 mg : Oral
Quantity (per dose): *** 1 *** (One)
Unit: tab(s)
Route: Oral
Schedule: every four hours as needed
Dispense (total): *** 10 *** (Ten)
No Refills
May Substitute
Prescriber DEA: BG7723340
Prescriber Medical License Number: OS010714L

Known Allergies: 0 none, No known drug allergies

Questions or Concerns – Please contact:
St. Mary Medical Center
Emergency Department
Langhorne, Pennsylvania 19047
215-710-2100

ST MARY MEDICAL CENTER
DISCHARGE INSTRUCTIONS

with water. This will allow it to come off easier.
Apply antibiotic ointment to the burn several times a day and cover it with a clean, dry dressing. Polysporin ointment, Silvadene cream, and Bacitracin ointment are over-the-counter antibiotic ointments that are commonly used for burn care.
YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS:
- Unusual redness or swelling.
- Red streaks extending from the wound.
- Foul drainage or odor from the wound.
- Pain with movement of the extremity and / or swollen lymph nodes (nodules that are usually found in the groin, armpit and neck).
- Fever, chills, increasing pain and / or swelling.

PRESCRIPTIONS

Vicodin : Tablet : 500 mg-5 mg : Oral
Dispense: 10, Quantity: 1, Unit: tab(s), Route: Oral, Schedule: every four hours as needed

St. Mary Medical Center

Name: Mayson. Maiellen
Age: 30Y DOB [illegible], 1980
Gender: F Wt: 65.8 Kg Ht: 157 cm.
MedRec: 3303559
AcctNum: LP0309925865
Attending: PLG
Primary RN: NAM
Bed: ED 2–C 12

ST MARY MEDICAL CENTER
DISCHARGE INSTRUCTIONS

Thank you for choosing St Mary Emergency Department!

Our goal is to provide you with great service. If your service was great, we met our goal! Please return the survey you receive in the mail with Definitely Yes "Would Recommend"

If for any reason you can not choose "Definitely Yes" ...
Please contact me, WE WANT TO KNOW!

Lisa Goldsmith, RN
Emergency Department Manager
215–710–4625

FINAL DIAGNOSIS
Partial thickness burns, face/neck

TREATED BY:
Attending Physician – Geisler, DO, G.Larry
Primary Nurse(s) – McElroy, Amy; Moyer, Suzzanne

FOLLOWUP CONTACTS

DOCTOR NONE, Medicine Family Practice
1205 LANGHORNE–NEWTOWN ROAD
LANGHORNE
LANGHORNE PA

Follow up with Primary Care Physician 1–2 Days

SPECIAL INSTRUCTIONS
Return if worse or with other concerns
Apply antibiotic ointment to areas twice daily. Must return to Laser center to re–evaluate areas.

MEDICAL INSTRUCTIONS

BURNS
You have been seen for a burn.
Burns can be divided into one of three categories:
– First–degree burns. These are relatively minor burns and involve only the superficial layer of skin. The skin is red and painful without blistering. These burns usually heal without scarring. A bad sunburn is an example of a first–degree burn.
– Second–degree burns. These burns are more serious and involve deeper layers of the skin. The skin is red, painful, with blisters. Scarring may result from second degree burns.
– Third–degree burns. These burns involve deep layers of the skin and always result in some degree of scarring. These burns may or may not be painful.
Remove old dressings daily and apply a clean dry dressing. If the dressing sticks to the wound, slightly moisten it

KOLE PLASTIC SURGERY CENTER

Edward S. Kole, D.O.
Board Certified
Plastic and Reconstructive Surgery

Cosmetic Surgery
Reconstructive Surgery
Hand Surgery

August 9, 2011

Neal Newman, Esquire
86 Buck Road
Holland, Pa 18966

RE: MAIELLEN MAYSON
DOI: 7/5/10

Dear Mr. Newman:

I had the pleasure of seeing Ms. Maiellen Mayson for consultation. As you recall she is currently a 32-year-old black female who was initially seen on July 19, 2010. She stated that approximately two weeks prior to that date was treated at the American Laser Center for hair removal on her chin and anterior neck. She then stated blistered that day and she called that center and they gave her Neosporin and recommended ice. She then stated the pain increased and she went to the emergency room at which time she was given vicodin and triple antibiotic ointment. The records of the American Laser Center were provided and reviewed.

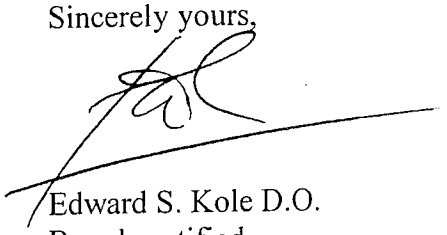
Physical examination that time revealed she had multiple visible lines secondary to laser passes on her central and left neck and her chin. There is a central stripe of hypopigmentation peripherally and a hyperpigmented area interspersed between the normal appearing skin. This was secondary to the pigmentation abnormalities occurred by the laser passes overlap. At that time it was explained to the patient that she should have strict avoidance of ultraviolet exposure and she must wear sun block daily and at the time it was not sure whether she would hyper or hypo pigment because she had both light and dark skin scars from previous traumas.

She was then seen again on January 21, 2011 at which time she had significant hyperpigmentation of her neck. The patient states that it is very disturbing and causing her cosmetic difficulties and problems with self esteem. The patient currently wanted electrolysis for hair removal and I told her that this was probably not a good idea because of her previous hyperpigmentation issues. Again she is instructed to avoid tanning beds and use 30 plus SPF and wear sun block daily.

DISCUSSION: Although she does not have permanent scaring, she has significant hyperpigmentation as a direct result of the laser treatments performed at the American Laser Center. Ms. Mayson will have to significantly curtail her sun exposure and a change her current way of life and as he needs to wear sunblock daily and have strict avoidance of the sun and tanning salons to decrease the risk of further post inflammatory hyperpigmentation. A course of Vaniqua was prescribed for the patient. This was done to hopefully prevent the need for future electrolysis treatment because I feel that electrolysis may also cause hyperpigmentation in this patient. These statements were made with a

reasonable degree of medical certainty. If you have any questions regarding this report please and I hesitate to contact my office.

Sincerely yours,



Edward S. Kole D.O.
Board-certified
Plastic and Reconstructive Surgery

KOLE PLASTIC SURGERY CENTER

Edward S. Kole, D.O.
Board Certified
Plastic and Reconstructive Surgery

Cosmetic Surgery
Reconstructive Surgery
Hand Surgery

September 30, 2011

Neal Newman, Esquire

86 Buck Road

Holland, Pa 18966

Addendum: Maiellen Mason

Dear Mr. Newman:

Although there is no permanent scarring from the laser treatments, it should be noted that her pigmentation abnormalities will follow her throughout her life and should be considered a permanent impairment the laser treated areas of her skin in. She will have to change her lifestyle significantly to hopefully decrease the appearance of these hyperpigmented areas. This lifestyle modification would include the use of hydroquinone bleaching cream, strict avoidance of sun and tanning beds and the use of daily high- SPF sunblock.

Sincerely yours,

Edward S. Kole, D.O

Board Certified

Plastic and Reconstructive Surgery

KOLE PLASTIC SURGERY CENTER

Edward S. Kole, D.O.

PATIENT Mueller Mayson DOB: '10 AGE: 3D (for hair removal)

Chief Complaint burn chin + neck from laser 2nd treatment

Date of Onset 7/5/10 (Legal case) Work / Auto / (Other) Am. Laser Cent

Family Physician: _____ Phone: _____

Allergies: None Medications: None

Medical Conditions:

1) None

2) _____

3) _____

Past Surgical Hx:

None

Positive Findings: Fitzpatrick 6-Type

Height 5'1 Weight 135 165

3 mos. ago

Laser @ Am. Laser Center for Hair removal

JUL 19 2010

2nd tx for hair removal.

chin + ant neck blistered that day → ice + neosp + Triple Abx ointment. → ↑ pain → ER spoke to cen

Vicodin: + Triple Abx ointment.

Test spot ? + ungke

DIAGNOSIS: ICD-9 Code: _____

1) _____

2) _____

3) _____

4) PE: multpl lins laser pass central + L neck + chin central strip — hypopigment peripheral — hyperpigment interspersed w/in unaffected skin

OPERATIVE PROCEDURE: _____

Must wear sunblock daily

TREATMENT PLAN: No UV exposure

Not sure if will ↑ pigment or fade will ↓ in few months

Physician: _____

Surgical Booking Information: SDA / SPU / MOPS / Surgery

P.O. appointment needed _____ days	Date for 1st P.O. appointment _____
Hospital: Office	**Anesthesia:** Local/Mac Gen. Spinal Regional
Duration / Hrs:	**Date of Surgery:** **Time:** am / pm
Scheduled by: _____ with _____ Date: _____ Time: _____	
P.A.T.'s _____ Patient informed: _____ Referrals needed: Yes No	
Primary Called: Spoke To: Date: Time:	

CPT Code: _____

Insurance Information:

Insurance: Phone #:	Insurance: Phone #:
Add'l info needed:	Add'l info needed:
Spoke To: Date: Time: am/pm	Spoke To: Date: Time: am/pm
Pre Certification #	Pre Certification #
Referrals needed: Yes No	Referrals needed: Yes No

Photos Taken: (Yes) No Date: 7/15 (Camera) Imaging Polaroid

The Swain Law Firm, P.C.

ANDREW D. SWAIN * ▫

* ADMITTED TO PA & NJ BARS
▫ LL.M. IN TRIAL ADVOCACY

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NEW JERSEY OFFICES
CAMDEN CO.
2091 SPRINGDALE RD, STE. 2
CHERRY HILL, NJ 08003

ATLANTIC COUNTY
605 NEW ROAD
LINWOOD, NJ 08221

February 14, 2012

United State Bankruptcy Court
Atten: Claims
824 Market Street, 3rd Floor
Wilmington, DE 19801

Re:	My Client:	Mai-Ellen Mayson (Maiellen Mayson)
	DOB:	01/22/80
	ALC Patient ID:	1039641
	Date of Incident:	07/02/2010

Dear Sir/Madam:

Enclosed please find the original and a copy of Ms. Mayson's Proof of Claim. Kindly file the original and forward a time- stamped copy back to our office in the self-addressed, stamped envelope provided for your convenience.

I am also enclosing a copy of records from American Laser Centers and color copies of photographs of Ms. Mayson for your review.

Thank you.

Very truly yours,

s/Andrew D. Swain, Esq.

Andrew D. Swain, Esq.

.mtw

Encl.

FedEx. *US Airbill* Express

FedEx Tracking Number: 8726 8134 8931

0200 — Recipient's Copy

1 From

Date: 2/27/12

Sender's Name: [redacted] Phone: [redacted]

Company: [redacted]

Address: [redacted] Dept./Floor/Suite/Room: [redacted]

City: [redacted] State: [redacted] ZIP: [redacted]

RECEIVED
MAR 01 2012
BMC GROUP

2 Your Internal Billing Reference

3 To

Recipient's Name: [redacted] Phone: [redacted]

Company: [redacted]

Address: [redacted] Dept./Floor/Suite/Room: [redacted]
We cannot deliver to P.O. boxes or P.O. ZIP codes.

Address: [redacted]
Use this line for the HOLD location address or for continuation of your shipping address.

City: [redacted] State: [redacted] ZIP: [redacted]

☐ HOLD Weekday — FedEx location address REQUIRED. NOT available for FedEx First Overnight.

☐ HOLD Saturday — FedEx location address REQUIRED. Available ONLY for FedEx Priority Overnight and FedEx 2Day to select locations.

8726 8134 8931

4a Express Package Service * To most locations. — *Packages up to 150 lbs.*

- ☐ FedEx Priority Overnight — Next business morning.* Friday shipments will be delivered on Monday unless SATURDAY Delivery is selected.
- ☑ FedEx Standard Overnight — Next business afternoon.* Saturday Delivery NOT available.
- ☐ FedEx First Overnight — Earliest next business morning delivery to select locations.* Saturday Delivery NOT available.
- ☐ FedEx 2Day — Second business day.* Thursday shipments will be delivered on Monday unless SATURDAY Delivery is selected.
- ☐ FedEx Express Saver — Third business day.* Saturday Delivery NOT available.

4b Express Freight Service ** To most locations. — *Packages over 150 lbs.*

- ☐ FedEx 1Day Freight — Next business day.** Friday shipments will be delivered on Monday unless SATURDAY Delivery is selected. FedEx 1Day Freight Booking No.
- ☐ FedEx 2Day Freight — Second business day.** Thursday shipments will be delivered on Monday unless SATURDAY Delivery is selected.
- ☐ FedEx 3Day Freight — Third business day.** Saturday Delivery NOT available.

5 Packaging * Declared value limit $500.

- ☐ FedEx Envelope*
- ☑ FedEx Pak* — Includes FedEx Small Pak and FedEx Large Pak.
- ☐ FedEx Box
- ☐ FedEx Tube
- ☐ Other

6 Special Handling and Delivery Signature Options

☐ SATURDAY Delivery — NOT available for FedEx Standard Overnight, FedEx Express Saver, or FedEx 3Day Freight.

- ☐ No Signature Required — Package may be left without obtaining a signature for delivery.
- ☐ Direct Signature — Someone at recipient's address may sign for delivery. Fee applies.
- ☐ Indirect Signature — If no one is available at recipient's address, someone at a neighboring address may sign for delivery. Fee applies. For residential deliveries only.

Does this shipment contain dangerous goods?

One box must be checked.

- ☐ No
- ☐ Yes — As per attached Shipper's Declaration.
- ☐ Yes — Shipper's Declaration not required.
- ☐ Dry Ice — Dry Ice, 9, UN 1845 ____ x ____ kg
- ☐ Cargo Aircraft Only

Dangerous goods (including dry ice) cannot be shipped in FedEx packaging or placed in a FedEx Express Drop Box.

7 Payment *Bill to:*

- ☐ Sender — Acct. No. in Section 1 will be billed.
- ☐ Recipient
- ☐ Third Party
- ☐ Credit Card
- ☐ Cash/Check

Enter FedEx Acct. No. or Credit Card No. below. Obtain recip. Acct. No. ☐

Total Packages | Total Weight | Total Declared Value† | Credit Card Auth.

____ ____ lbs. $ ____ .00 ____

†Use liability is limited to $100 unless you declare a higher value. See the current FedEx Service Guide for details.

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