Wrinkle Relaxer & Cosmetic Filler

Guest Information Form

ENVIZION Medical

Patient Name:_____ Date: _____

Have you ever had botulinum toxin product? (Botox/Dysport/Myobloc/Xeomin) ☐ Yes ☐ No

Have you ever had Dermal Fillers? (Restylane/Perlane/Juvaderm/Collagen/Sculptra) ☐ Yes ☐ No

Have you ever had surgical implants in the lips/face? ☐ Yes ☐ No

If YES, last treatment date?_____What areas?_____

Any complications?_____

Do you have a history of any of the following?

*Contraindications

☐ Yes ☐ No Under age of 18

☐ Yes ☐ No Pregnant/Breastfeeding

☐ Yes ☐ No Inflammation at Injection Site

☐ Yes ☐ No Allergy to Lidocaine

☐ Yes ☐ No History of bleeding disorder

☐ Yes ☐ No Allergy to Human Albumin

☐ Yes ☐ No Allergy to cow's milk protein

☐ Yes ☐ No Autoimmune/Neurological Disease

(Ex. ALS-Lou Gehrig's disease, Parkinson's disease,

Myasthenia Gravis, MS, Lambert-Eaton Syndrome)

☐ Yes ☐ No Swallowing or Breathing Problems

☐ Yes ☐ No Allergy to Gram + Bacteria

☐ Yes ☐ No History of anaphylaxis or shock

☐ Yes ☐ No History or presence of severe allergies

*Cautions

☐ Yes ☐ No Allergy to Visine (Benzyl alcohol)

☐ Yes ☐ No Bell's Palsy

☐ Yes ☐ No Trigeminal Neuralgia

☐ Yes ☐ No Vision Problems

☐ Yes ☐ No Numbness/ facial muscle weakness

☐ Yes ☐ No Droopy/sagging/excess eyelid skin

☐ Yes ☐ No History of peri-oral herpes

☐ Yes ☐ No Use of anti-coagulants/blood thinners

☐ Yes ☐ No Recent antibiotic injection

☐ Yes ☐ No Muscle relaxant, allergy/cold medic.

☐ Yes ☐ No Sunburned/irritated/rash on skin

☐ Yes ☐ No Recent use of Retin A in past 2-3 days

☐ Yes ☐ No Use of Immunosuppressants

List/Explain any other medical conditions not listed above: _____

_____

Patient's Signature: _____ Date: _____

Provider Signature: _____ Date: _____

PATIENT CONSENT TO ALL ENVIZION MEDICAL SERVICES Please initial, indicating you understand and agree with the following statements:

___ The number of patients we see is limited by appointment only. Missed appointment's cause an inconvenience to other patients. Please notify us twenty-four hours in advance if you are unable to keep your appointment. In the event that a patient does not show for an appointment or does not cancel with 24 hours notice, their next appointment will require a $50 non-refundable deposit.

___Most health insurance companies typically do not provide coverage for medically monitored weight-loss, Aesthetics, and Bio-Identical Hormone Therapy. Therefore, we do not take any form of payment from third party companies and all services must be paid for at the time services are rendered by cash, check, or credit card.

___I understand that some of the treatments suggested for me are as yet unproven and experimental, however, I have been informed of this, and I am willing to accept the risks on the basis of the information provided to me. I will have an opportunity to ask questions and to research any treatment suggested before I agree to do it. I understand that the doctors have done their research as well, including, (in most cases) have taken these treatments themselves.

___I understand any treatments rendered through Envizion Medical are solely for The purpose of hormone balancing/restoration, body-fat reduction, and preventative Medicine. We are not capable of serving as your primary care facility. If I become ill, I Should contact my personal physician or visit an urgent care facility. If I become ill, I will discontinue any diet or weight-loss medication from this clinic until it is determined safe to Resume the weight control program.

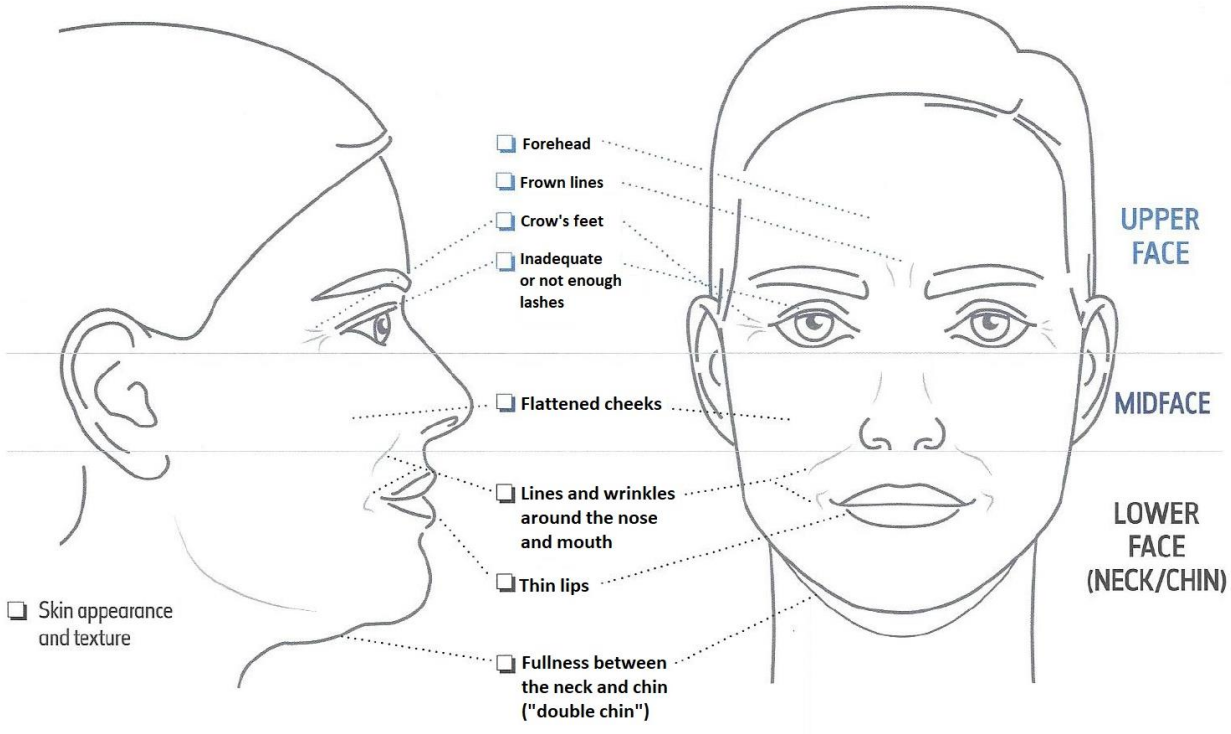
___I understand that NO PRESCRIPTION WILL BE PROVIDED UNLESS A CLINICAL NEED EXIST BASED ON REQUIRED LAB WORK, PHYSICIAN CONSULTATION, PHYSICAL EXAMINATION AND/OR CURRENT MEDICAL HISTORY. PLEASE NOTE, AGREEING TO LAB WORK AND PHYSICAL EXAM DOES NOT AUTOMATICALLY EQUATE TO A PRESCRIPTION.

NOTICE OF PRIVACY PRACTICES:
THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.
SUMMARY: By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.
As a patient, you have the following rights:

1. The right to inspect and copy your information
2. The right to request corrections to your information
3. The right to request that your information be restricted
4. The right to confidential communications
5. The right to report a disclosure of your information
6. The right to a paper copy of this form

We want to assure you that your medical/protected health information is secure with us. If you have any questions regarding this form please contact one of the office staff at Envizion.
I hereby acknowledge that I have received a copy of these practices NOTICE OF PRIVIACY PRACTICES. I understand that if I have a question or complaint regarding my privacy rights that I may contact a member of the staff at Envizion. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way.

Self Assessment: Please select which areas of the face concern you on the diagram below.



Patient Name (Please Print) _____

Patient Signature_____

Date: _____

BOTOX® CONSENT FORM

I have requested attempts to improve my facial expression lines with Botox® (Botulism toxin). Injection of minute amounts diminishes frowning, crow's feet, and expression lines. Botox® only treats wrinkles produced by facial muscle activity. Wrinkles present at rest may not improve. Although the results are usually dramatic, I have been informed that the practice of medicine is not an exact science and that no guarantee has been made concerning expected results. It is possible that no improvement may result, and that a larger quantity of product may have to be injected for an additional fee. **Initial_____**

The solution is injected with a small needle into the muscle. The benefits develop over the next 7-10 days. Typically, the injected muscle regains its action in 2-3 months and wrinkles produced by the muscle activity would then reoccur. At this point, a repeat treatment will relax the muscle and soften lines again. **Initial_____**

Slight swelling, and/or bruising may occur and last for several days after the injections. Rarely, an adjacent muscle may be weakened for several weeks after treatment. Among the reported rare side effects are; headache, asymmetry, twitching, numbness, temporary drooping of the eyelids or eyebrows, double vision, nausea, and flu-like symptoms. **Initial_____**

Alternative treatments have been discussed with the patient. I have been advised of the risks involved with such treatment, the expected benefits, alternate options, including no treatment. **Initial_____**

Several sessions may be needed to complete the injection series. **Initial_____**

I am not pregnant and have no significant neurological disease. **Initial_____**

Botox® has been FDA approved for use in the glabellum. Use in other sites is considered "off label". Treatment in other areas for wrinkles may be considered "innovative". Although most of the known risks have been outlined above, there is a theoretical risk of unknown complications when a drug is used for off-label use. **Initial_____**

This procedure is cosmetic in nature and not covered by my insurance company. I understand that payment is my responsibility and due in full on the day of my procedure. **Initial_____**

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs. I have had sufficient opportunity for discussion and to ask questions. **Initial_____**

_____ _____ _____

Print Patient Name | Patient Signature | Date

JUVÉDERM™ Consent Form

Indications

JUVÉDERM™ Ultra injectable gel is injected into areas of facial tissue where moderate to severe facial wrinkles and folds occur. It temporarily adds volume to the skin and subcutaneous tissues may give the appearance of a smoother skin surface and may help smooth moderate to severe facial wrinkles and folds. Correction is temporary; therefore, touch-up injections as well as repeat injections are usually needed to maintain optimal correction. Less material (about half the amount) is usually needed for repeat injections. Most patients need one or possibly two treatments to achieve optimal wrinkle smoothing. The results may last as long as 9 months to 1 year. **Initial_____**

Side Effects and Complications Most side effects are mild or moderate in nature, and their duration is short lasting (7 days or less). The most common side effects include, but are not limited to, temporary injection-site reactions such as: redness, pain/tenderness, firmness, swelling, lumps/bumps, bruising, itching, infection and discoloration. In the first 24 hours after injection, you should avoid strenuous exercise, extensive sun or heat exposure, and alcoholic beverages. Exposure to any of the above may cause temporary redness, swelling, and/or itching at the injection sites. If there is swelling, you may need to place an ice pack over the swollen area. You should ask your physician when makeup may be applied after your treatment. Be sure to report any redness and/or visible swelling that last for more than a few days, or any other symptoms that cause you concern. **Initial_____**

Contraindications

JUVÉDERM™ Ultra injectable gel should not be used if you have: • Severe allergies marked by a history of anaphylaxis or history or presence of multiple severe allergies • A history of allergies to Gram-positive bacterial proteins. **Initial_____**

The following are important treatment considerations for you to discuss with us and understand in order to help avoid unsatisfactory results and complications: • Please inform us prior to treatment: If you are using substances that can prolong bleeding, such as aspirin or ibuprofen, as with any injection, may experience increased bruising or bleeding at the injection site. • Please inform us prior to treatment: If you are on immunosuppressive or therapy used to decrease the body's immune response, as there may be an increased risk of infection • Please inform us prior to treatment: If you are pregnant or breastfeeding, • Please inform us prior to treatment: If you have history of excessive scarring (eg, hypertrophic scarring and keloid formations) and pigmentation disorders. **Initial_____**

If laser treatment, chemical peeling, or any other procedure based on active dermal response is considered after treatment with JUVÉDERM™ Ultra injectable gel, there is a possible risk of an inflammatory reaction at the treatment site. **Initial_____**

The safety and effectiveness of JUVÉDERM™ Ultra injectable gel for the treatment of areas other than facial wrinkles and folds (such as lips) have not been established in controlled clinical studies. PATIENT'S ACCEPTANCE OF RISKS **Initial_____**

I have read the above information and have discussed it with my physician. I understand that it is impossible to be informed of every possible complication that may occur. No guarantees about results have been made. By signing below, I agree that my doctor has answered all of my questions and that I understand and accept the risks, benefits, and alternatives of JUVÉDERM™ Ultra **Initial_____**

_____ _____ _____

Print Patient Name Patient Signature Date