Dermal Filler & Neurotoxin

Consultation Form

JUDY_INJECTS

Email/Newsletter

Would you like to be added to our subscriber list in order to receive information about upcoming discounts, promotions, contests etc?

- ○ *Yes, subscribe me!*
- ○ *No, thanks*

Appointment date _____ *Appointment time* _____

Personal Information

FULL NAME PHONE#:

D.O.B. AGE: PHARMACY:

ADDRESS:

To perform the Dermal Filler & Botox procedure in a safe manner, please answer the following health questions truthfully. We will keep all information disclosed in a confidential manner and will use it only for purposes of determining whether you are an ideal candidate for this procedure.

Have you ever had botox or dermal fillers? ☐ Yes ☐ No

If yes, when were you last treated: .....

Any complications? ..... ☐ Yes ☐ No

How did you hear about us? .....

MEDICAL HISTORY

Are you currently under the care of a physician?

If yes, for what? .....

Are you pregnant or trying to get pregnant?

Are you breastfeeding?

Are you using contraception?

What oral prescription medications are you presently taking?

If yes, please list .....

Are you presently taking any of the following medication or supplements listed below?

- ☐ Aspirin
- ☐ Mood altering medication
- ☐ Fish Oil
- ☐ Garlic
- ☐ Licorice
- ☐ Blood thinners
- ☐ Anti-depression medication
- ☐ COQ10
- ☐ Omega 3 fatty acids
- ☐ Ginger
- ☐ Flax seed oil
- ☐ Hormones
- ☐ Vitamin E
- ☐ Ginkgo biloba
- ☐ Cayenne

Do you have any chronic medical conditions? ☐ Yes ☐ No

If so, please describe .....

Do you have any allergies? ☐ Yes ☐ No

If so, please describe .....

Have you ever had an allergic reaction to the following?

☐ Food ☐ Animal Protein ☐ Aspirin ☐ Eggs ☐ Collagen

☐ Lidocaine (Anesthetic) ☐ Hydroquinone or skin bleaching agents

☐ Hydrocortisone ☐ Others .....

PLEASE INDICATE IF ANY OF THE FOLLOWING APPLY TO YOU:

- ☐ Inflammations or infections on skin (cysts, pimples, rashes, or hives)
- ☐ Bleeding disorder
- ☐ Severe allergies or have a history of anaphylaxis (acute allergic reaction)
- ☐ Cancer
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Herpes
- ☐ Arthritis
- ☐ Frequent cold sores
- ☐ HIV/AIDS
- ☐ Keloid scarring
- ☐ Skin disease
- ☐ Skin lesions
- ☐ Seizure disorder
- ☐ Hepatitis
- ☐ Hormone imbalance
- ☐ Thyroid imbalance
- ☐ Blood clotting abnormalities
- ☐ Any active infection
- ☐ Heart conditions

FACIAL HISTORY

What bothers you most about your facial appearance? .....

What are your expectations for today's visit? .....

Do you regularly sun bathe or use tanning salons? ☐ Yes ☐ No *How often?* .....

What topical medications or creams are you currently using? ☐ Retin ☐ Other

Please list .....

Have you waxed, tweezed, bleached or used hair removal cream withing the last week? ☐ Yes ☐ No

Please list .....

Have you taken any Aspirin, Ibuprophen, Motrin, Tylenol, Fish Oil, Vitamin E, Blood Thinners, Alcoholic Beverages in the last ten days? ☐ Yes ☐ No

If yes, what? .....

FACIAL INJURY TRAUMA HISTORY

Is there any history of facial surgery? ☐ Yes ☐ No

Please describe .....

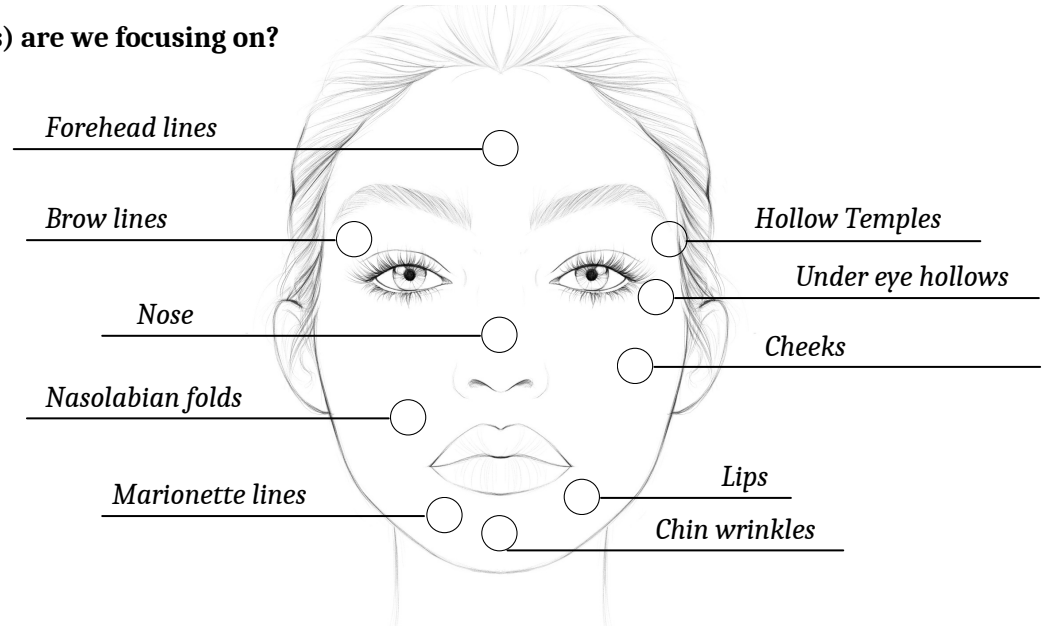
Is there any recent history of trauma to the head or face? ☐ Yes ☐ No

Please describe .....

Any TMJ problems? ☐ Pain ☐ Clenching ☐ Grinding

Please describe .....

What area(s) are we focusing on?



I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform my therapist or other health professional of my current medical health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures

Date:_____ Date: _____

Client Name (Printed) _____ Health Care Provider: Perla Cedillo RN, MSN, FNP

Client Signature _____ HCP Signature _____

JUDY_INJECTS

JUDY_INJECTS

Informed Consent Form

THE TREATMENT

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

Treatment with dermal fillers (such as Juvederm Ultra and Ultra Plus, Restylane, Belotero, Radiesse, Voluma and others can smooth out facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure, illness, etc. Facial rejuvenation can be carried out with minimal complications. These dermal fillers are injected under the skin with a very fine needle. This produces natural appearing volume under wrinkles and folds which are lifted up and smoothed out. The results can often be seen immediately

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extend outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1) Post treatment discomfort, swelling, redness, bruising, and discoloration; 2) Post treatment infection associated with any transcutaneous injection; 3) Allergic reaction; 4) Reactivation of herpes (cold sores); 5) Lumpiness, visible yellow or white patches; 6) Granuloma formation; 7) Localized necrosis and/or sloughing, with scab and/or without scab if blood vessel occlusion occurs.

PREGNANCY AND ALLERGIES

I am not aware that I am pregnant, I am not trying to get pregnant, I am not lactating (nursing), I do not have or have not had any major illnesses which would prohibit me from receiving dermal fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine. Initial: _____

ALTERNATIVE PROCEDURES

Alternative procedures and options that I have volunteered for have been fully explained to me

PAYMENT

I understand that this is an “elective” procedure and that payment is my responsibility and is expected at the time of treatment.

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time.

RESULTS

Dermal fillers have been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines and folds in the skin on the face. Its effect can last up to 2 years. Most patients are pleased with the results of dermal fillers use. However, like any esthetic procedure, there is no guarantee that you will not require additional treatments to achieve the results you seek. The dermal filler procedure is temporary and additional treatments will be required periodically, generally within 4-6 months and up to one year, involving additional injections for the effect to continue.

I am aware that follow-up treatments will be needed to maintain the full effects. I am aware the duration of treatment is dependent on may factors but not limited to: age, sex, tissue conditions, my general health and life style conditions, and sun exposure. The correction, depending on these factors, may last up to 1 year and in some cases shorter and some longer. I have been instructed in and understand the post-treatment instructions.

CONSENT

I have read and understand this document entitled: Informed Consent for Injection of Dermal Filler I hereby authorize Perla Cedillo RN, MSN, FNP
to perform the following procedure: Injection of Dermal Filler.

_____ I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.

_____ I will follow all aftercare instructions as it is crucial to do so for good healing and to minimize the risk of complications.

_____ I am aware that smoking during the pre and post operative periods could increase chances of complications.

_____ I have informed my therapist of all my known allergies, including allergies to latex.

_____ I have informed my therapist of all medications I am currently taking including prescriptions, over the counter medications/remedies, herbal therapies and any other.

_____ I am aware and accept that no guarantees regarding the result of this procedure have been made or implied.

_____ I have been advised to seek immediate medical attention if swallowing, speech, or respiratory disorders arise.

_____ I consent to the photographing of the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes and/or for publication, provided my name is not revealed by the pictures and complete confidentiality of my name will be maintained.

I understand this is an elective procedure and I hereby voluntarily consent to treatment with dermal fillers for facial rejuvenation, lip enhancement, establish proper lip and smile lines, and replacing facial volume. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/ healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

I agree to pay _____ for the above mentioned service. _____

Date: _____

Client Name _____ Health Care Provider: Perla Cedillo RN, MSN, FNP

Client Signature _____ HCP Signature _____

DERMAL FILLER

JUDY_INJECTS

Pre-treatment Advice

What to do to prepare for dermal fillers?

- DO educate and prepare yourself before getting dermal fillers
- Avoid taking aspirin or other non-steroidal anti-inflammatory drugs such as Ibuprofen, Advil®, Motrin®, Nuprin®, Aleve®, Celebrex®, Fish oil, Gingko Biloba , St. John's Wort and high doses of vitamin E for at least 7-10 days before your appointment, unless medically necessary.
- You may take Tylenol® (if not contraindicated) one hour before your appointment to prevent any discomfort you may experience. If you have concerns about discomfort.
- If you are taking prescription blood thinners such as Coumadin or Plavix, you should check with the prescribing doctor to see if you are able to stop these medicines for 7-10 days before your appointment and at least 2 days after the procedure has been done.
- If you have any history of Herpes Simplex (cold sores) on your face, make sure you inform the doctor that you have made your appointment with, one week prior to your appointment; this will allow us adequate time to prescribe a medication to prevent an outbreak.

Schedule your injection at a time when minor swelling or bruising will not disrupt your social obligations

Avoid dental procedures 2 weeks pre filler and 2 weeks post filler

Come to your appointment with a clean face. **This means NO MAKEUP or MOISTURIZER**

Avoid alcohol, caffeine, high sugar foods, spicy foods and cigarettes 24 h before treatment

Eat a small meal or a snack before your appointment.

Discontinue using Retin-A 2-3 days before treatment

Bruising and swelling will be worse for the first 24-48 hours after you receive your dermal filler injections. Refrain from exercising for the remainder of the day following your injection(s). You may want to refrain from going to any special events during this time.

It is recommended that you wait at least 2 weeks to have dermal filler treatments performed if you have previously had cosmetic treatments with laser, ultrasound, peels, facials or micro-dermabrasion

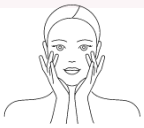
Post-treatment Advice

What to do to after your treatment?

Studies have shown that having a follow-up treatment before the product has fully dissipated will enhance the lasting effect. Consult your physician about recommendations for touch-up or followup treatments.

- The majority of reactions to dermal fillers are redness, swelling, bruising and tenderness after the injections. These usually subside a few days after the treatment, but can last up to a week. If any of these symptoms persist longer than a week, or if you develop other symptoms, please contact our office.
- Cold compresses may NOT be used after the treatment. You may take Tylenol (if not contraindicated) every 4-6 hours after the treatment to help with any discomfort you may have.
- In the first 24 hours following treatment, limit exposure to sunlight or UV lamps. Extensive sun or heat exposure and alcoholic beverages may cause a temporary increase in redness, bruising or swelling at the injection sites. If there is persistent swelling or redness after the injections, you should limit exposure to sunlight or UV lamps until these symptoms subside (for at least 5-7 days). If sun exposure is unavoidable, use a sun block with an SPF of 30 or greater, combined with zinc oxide and/or titanium dioxide.
- Avoid taking aspirin (unless medically necessary) or other non-steroidal anti-inflammatory drugs such as Ibuprofen, Advil®, Motrin®, Nuprin®, Aleve®, Celebrex®, Fish oil, Gingko Biloba , St. John's Wort and high doses of vitamin E for 5 days after the treatment, as these may cause an increased risk of bleeding or bruising at the injection sites.

Do not apply anything to the skin until the day after treatment: No cleanser, moisturizer, or makeup!



Do not massage, touch, or manipulate the injection site. Avoid heavy exercise the day of your treatment.

Do not apply ice packs to the treated area .

Wait minimum 4 weeks before receiving any skin care or laser treatments.

If experiencing swelling, sleep with head elevated for 2-3 days to decrease swelling.

Avoid direct sunlight and do not forget using the sunscreen

Cosmetic fillers are long lasting, but not permanent. Longevity depends on the areas treated and your body's metabolism.

JUDY_INJECTS

COVID-19 LIABILITY RELEASE WAIVER

THIS FORM MUST BE COMPLETED AND SIGNED BEFORE TREATMENT

The World Health Organization has declared the novel Coronavirus (COVID-19) a worldwide pandemic. Due to its capacity to transmit from person-to-person through respiratory droplets, the government has set recommendations, guidelines, and some prohibitions which _____ adheres to comply.

Symptoms of COVID-19 include:

- Fever
- Fatigue
- Dry Cough
- Difficulty Breathing

I agree to the following:

- ☐ I, nor members of my household, have not experienced any of the symptoms listed above within the last 14 days.
- ☐ I, nor members of my household, have not travelled internationally in the last 30 days.
- ☐ I, nor members of my household, do not believe that we have been exposed to someone with a suspected and/or confirmed case of the Coronavirus (COVID-19).
- ☐ I, nor members of my household, have not been diagnosed with the Coronavirus (COVID-19) within the last 30 days.
- ☐ The venue cannot be held liable from any exposure to the Coronavirus (COVID-19) caused by misinformation on this form or the health history provided by each client.
- ☐ I understand that due to the frequency of visits of other clients, the characteristics of the virus, and the characteristics of these services that I have an elevated risk of contracting the virus simply by being in the establishment.

To prevent the spread of the contagious virus and to help protect each other, I understand that I must follow the establishment's guidelines:

- Reschedule appointment if you are feeling unwell;
- No additional guest is allowed;
- Wearing a mask is required upon arrival and during the entire procedure;
- Wash hands upon arrival;
- Limit conversation during the procedure.

By signing below, I agree to each above statement and release the venue and its employees from any and all liability for the unintentional exposure or harm due to Covid-19 and other communicable conditions.

Date: _____

Client Name (Printed) _____

Client Signature _____

JUDY_INJECTS

APPOINTMENT CANCELLATION POLICY

Dear Client,

We strive to render excellent care to you and the rest of our clients. Your care and treatment is a priority for us. We also ask that you respect your specialist's time and expertise as well.

In an attempt to be consistent with this, we have a Cancellation Policy that allows us to schedule appointments for our clients, with respect for your time, the next client's time, and the specialist's time.

Our policy is as follows:

We request that you give a notice **not later than 24 hours** prior to your scheduled appointment in the event that you can not make it. If the client misses an appointment without contacting us, it is considered a missed or "No Show" appointment. Additionally, if a client is more than 30 minutes late for an appointment, it will be considered as " No Show" appointment, and that appointment will be rescheduled. Also, if you miss more than 3 (three) appointments, we reserve the right to charge you a fee of _____$75.00_____.

A ___$50.00____ non refundable deposit will be paid at time of making appointment and will be taken off at the time of the appointment.

If you have questions regarding this policy, please let us know, and we will be happy to clarify our policy for you.

I have read and understand the Appointment Cancellation Policy, and I agree to be bound by its terms. I am aware that my credit card will be charged for the missed appointment, and I agree to this terms.

I, _____ , have received the copy of Cancellation Policy.

Date: _____

Client Name (Printed) _____

Client Signature _____