COSMETIC INJECTABLE

INFORMED CONSENT

PATIENT NAME
____

TREATMENT SITES
____

I DULY AUTHORIZE ________________ TO PERFORM ____________________ TREATMENT.

I understand that cosmetic injectable(s) is an elective cosmetic procedure and that this treatment is temporary and re-injection is necessary for sustained results.

I understand that clinical results may vary depending on individual factors, including but not limited to medical history, skin type, patient compliance with pre- and post-treatment instructions, and individual response to treatment.

No guarantees of results, have been or will be made. I understand that there is a possibility of minor and/or severe adverse effects that may include but not limited to: bruising, redness, swelling, pain at the injection site, tenderness, itching, allergic reaction, raised bumps of skin, as well as the possibility of rare side effects that may include but not limited to: skin defects, scarring, permanent skin discoloration and necrotic tissue, which may require additional surgery and/or pain, paralysis, uneven appearance to the treated area, post treatment infection. These adverse reactions have been explained to me and I've been provided the opportunity to review literature and answer questions to my satisfaction _______ (patient's initials).

I understand that treatment with this system involves a series of treatments for optimal results. Failure to comply with the treatment schedule, can lead to suboptimal outcomes and may require initiation of the entire treatment series, at my own expense _______ (patient's initials).

The fee structure has been fully explained to me and I have signed the master financial agreement _______ (patient's initials).

I’m aware that some procedures may require local anesthesia to maximize comfort. I’m aware of the potential side effects of receiving anesthesia, including but not limited to: compromised respiratory & cardiovascular systems, necessitating extraordinary life saving measures including cpr and intubation. I’ve signed the master anesthetic agreement ________(patient’s initials).

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is elective in nature and that the decision to proceed is based solely on my expressed desire to do so. I confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion ________(patient’s initials).

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotional marketing materials. Should a dispute arise between the practice and myself, social media will not be used as a medium for discussion of outcomes or care ________(patient’s initials).

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Patient Signature____
Date________________________________
Witness_____________________________

COSMETIC Patient Intake Forms

PERSONAL INFORMATION

NAME: ____

PHONE NUMBER: ____

ADDRESS: ____

CITY: ____

STATE: ____

ZIP CODE: ____

DATE OF BIRTH: ____

SKIN TYPE OF ASSESSMENT

ETHNICITY: ____

LAST EXPOSED TO OUTDOOR/INTENTIONAL OR INDOOR/TANNING BED EXPOSURE: ____

SELF-TANNING LOTION? YES/NO

NATURAL HAIR COLOR: ____

NATURAL EYE COLOR: ____

2.1.4 MEDICAL HISTORY

-PACEMAKER / DEFIBRILLATOR -METAL IMPLANTS -SKIN DISORDERS (SCARS, ABNORMAL WOUND HEALING, VITILIGO, KELOIDS, PSORIASIS, ECZEMA, HERPES SIMPLEX) -CURRENT OR HISTORY OF SKIN CANCER, OTHER CANCER OR SUSPICIOUS SKIN LESIONS/MOLES -PREGNANT AND/OR NURSING -HISTORY OF BLEEDING DISORDERS -SEVERE CONCURRENT MEDICAL CONDITIONS (HEART DISORDERS, SEIZURES) -MEDICATIONS OR TREATMENTS THAT INDUCE PHOTOSENSITIVITY -ACTIVE SKIN INFECTION -IMPAIRED IMMUNE SYSTEM -DISEASES STIMULATED BY LIGHT (LUPUS, PORPHYRIA, EPILEPSY)		YES/NO (if Yes, please describe in detail below) YES/NO (if Yes, please describe in detail below)	

-DIABETES MELLITUS (IF YES, WHAT IS YOUR CURRENT GLUCOSE RANGE) -PCOS -SAPHENOUS VEIN INSUFFICIENCY OR SEVERE VARICOSE VEINS		______ ______ ______ ______ ______ ______	

FACIAL LASER TREATMENTS, DEEP CHEMICAL PEELING AND/OR COSMETIC INJECTABLE TREATMENTS IN THE LAST 3 MONTHS: YES/NO (IF YES, PLEASE PROVIDE DATE/LOCATION OF LAST TREATMENT RECEIVED): ________________

NEEDLE EPILATION, WAXING OR TWEEZING, LAST 6 WEEKS: YES/NO (IF YES, PLEASE PROVIDE DATE/LOCATION OF LAST TREATMENT RECEIVED):

____

TATTOO OR PERMANENT MAKEUP? YES/NO (IF YES, PLEASE PROVIDE LOCATION): ____

CURRENT OR PAST HISTORY OF GOLD THERAPY? YES/NO (IF YES, PLEASE PROVIDE LOCATION): ____

PLEASE LIST ALL OF YOUR CURRENT MEDICATIONS:

____

____

LIST ALL OF YOUR DAILY SKIN CARE PRODUCT & DATE OF LAST USE:

____

____

ALLERGIES (MEDICATION & CONTACT/ENVIRONMENTAL):

CONSULTATION INFO

WHAT ARE YOUR AREAS OF CONCERN:

TREATMENT GOALS:

PROVIDER TREATMENT PLAN

TREATMENT PLAN (PROVIDER TO FILL OUT):

FITZPATRICK SKIN TYPE:

I II III IV V VI

FINANCIAL TREATMENT COST (PROVIDER TO FILL OUT):

(PATIENT SIGNATURE/DATE)

(PROVIDER SIGNATURE/DATE)

InMode Informed Consent

PATIENT NAME

____

TREATMENT SITES

____

I DULY AUTHORIZE ______________________________ TO PERFORM ___________________________ TREATMENT.

I understand that this device being used for an elective Hair Removal, Vascular Lesion Clearance, Skin Rejuvenation, Fractional Skin Resurfacing, Skin Tightening of which I am consenting to be a patient receiving ________________________________ treatment (specify procedure).

I understand that the Morpheus8 device is being used for subdermal and dermal remodeling of facial and body areas through fractional coagulation and sub-necrotic bulk heating of which I am consenting to be a patient receiving ________________________________ treatment (specify procedure).

I understand that clinical results may vary depending on individual factors, including but not limited to medical history, skin type, patient compliance with pre- and post-treatment instructions, and individual response to treatment.

No guarantees of results, have been or will be made. I understand that there is a possibility of adverse effects that may include but not limited to: temporary skin discoloration, mild burning, bruising, scarring, as well as the possibility of rare side effects that may include but not limited to: permanent scarring and skin discoloration, skin defects and necrotic tissue, which may require additional surgery and/or pain. These adverse reactions have been fully explained to me and I've been provided the opportunity to review literature and answer questions to my satisfaction ________ (patient's initials).

I understand that treatment with this system involves a series of treatments for optimal results. Failure to comply with the treatment schedule, can lead to suboptimal outcomes and may require initiation of the entire treatment series, at my own expense ________ (patient's initials).

The fee structure has been fully explained to me and I have signed the master financial agreement ________(patient's initials).

I'm aware that some procedures may require anesthetics to maximize comfort and I've signed the master anesthetic agreement. I'm aware of the potential side effects of receiving anesthesia, including but not limited to: compromised respiratory & cardiovascular systems, necessitating extraordinary life saving measures including cpr and intubation ________(patient's initials).

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so. I confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken, in a truthful and honest manor.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotional marketing materials. Should a dispute arise between the practice and myself, social media will not be used as a medium for discussion of outcomes or care.

I certify that I have been given the opportunity to ask questions, review literature and that I have read and fully understand the contents of this consent form.

Patient Signature____
Date________________________________
Witness_____________________________