Refine Aesthetics

CLIENT INFORMATION/MEDICAL HISTORY

Name _____Age_____ Date_____

Address_____City_____State_____Zip_____

Email Address_____

Cell_____ Date of Birth_____

Emergency Contact_____Relationship_____Cell_____

Medications (Prescriptions/over the counter med, vitamins, herbal medications)

_____

_____

Drug Allergies_____

Major Surgeries/Facial surgeries_____

Ongoing facial treatments? (Injectibles/Laser/chemical peels/waxing/facials)_____

Please circle if you have any of the following conditions –

Heart Disease Excessive Bleeding High Blood Pressure Hepatitis Skin Cancer Liver Disease

Lupus Auto-Immune Disorders Diabetes Neuromuscular Disease Cold Sores/Fever Blisters

Lidocaine allergy/sensitivity

Pregnant? Y N Breastfeeding? Y N

The above information is true and accurate to the best of my knowledge.

_____

_____ _____

Client Signature **Date**

TREATMENT CONSIDERATIONS FORM

The CoolSculpting® procedure is a non-invasive procedure that is intended to break down fat cells that are just beneath the skin by delivering controlled cooling at the surface of the skin. This procedure is not a treatment for weight loss. The CoolSculpting procedure does not replace traditional methods such as diet, exercise or liposuction. **Initial: ____**

Clinical studies have shown that the CoolSculpting procedure can break down fat cells to change the appearance of visibly localized bulges of fat that is just beneath the skin on the submental (under the chin) and submandibular (under the jawline) areas, thigh, abdomen and flank, along with bra fat, back fat, underneath the buttocks (also known as the banana roll) and upper arm. Following the procedure, the treated fat cells are naturally processed by the body over a period of months. Visible results can vary from person to person. **Initial: ____**

WHAT YOU CAN EXPECT:

Temporary Sensations / Symptoms:

The following effects can occur in the treatment area during and after a treatment. These effects are temporary and generally resolve within days or weeks.

» The suction pressure of a vacuum applicator may cause sensations of deep pulling, tugging and pinching. A surface applicator may cause sensations of pressure. You may experience intense cold, stinging, tingling, aching or cramping as the treatment begins. These sensations generally subside during treatment as the area becomes numb. **Initial: ____**

»The treated area may look or feel stiff after the procedure and transient blanching (temporary whitening of the skin) may occur. **Initial: ____**

» Bruising, swelling, redness, tenderness, cramping and aching can occur in the treated area and the treated area may appear red for one to two weeks after treatment. **Initial: ____**

» After submental or submandibular area treatment, a feeling of fullness in the back of the throat may occur. (Initial if the submental area is to be treated. If the area under the chin or jawline is not being treated, please write N/A.) **Initial: ____**

» You may feel numbness in the treated area that can last for several weeks after the procedure. Prolonged swelling, itching, tingling, numbness, tenderness to the touch, pain in the treated area, cramping, aching, bruising and/or skin sensitivity also have been reported. Numbness can last for several weeks after the treatment. **Initial: ____**

Potential Side Effects / Risks

» Paradoxical Hyperplasia - A small percentage of patients have experienced gradual development of visibly enlarged tissue in the treatment area. The enlarged tissue may feel hard and may appear in the shape of the applicator used during CoolSculpting® treatment. This may appear two to five months after treatment, is distinguishable from temporary swelling and will not resolve on its own. The enlargement requires surgical intervention for correction, such as liposuction. **Initial _____**

» Late-onset pain with a typical onset several days after a treatment and resolution within several weeks. **Initial**: _____

» You may have dizziness, light-headedness, nausea, flushing, sweating, or fainting during or immediately after the treatment. **Initial: ____**

» Treatment area demarcation -- A small percentage of patients have experienced excessive fat removal in the treatment area, resulting in an unwanted indentation. The indentation may be improved through corrective procedures. **Initial**: _____

» Some patients have reported the following conditions in areas of the body treated with CoolSculpting®: darker skin color, hardness, discrete nodules, burns, frostbite (local injury due to cold), nerve pain, deep vein thrombosis, extensive tissue damage and fat necrosis. Surgical intervention may be required to address these conditions if they develop. **Initial _____**

» Some patients have reported development of a hernia, or worsening of an existing hernia, following CoolSculpting treatment. Surgical intervention may be required to correct hernia formation or exacerbation. **Initial _____**

»Skin laxity can also develop in the treated area and surgical intervention may be required for correction. **Initial: ____**

» Patient experiences may vary. Some patients may experience a delayed onset of the previously mentioned symptoms. Contact your physician immediately if any unusual side effects occur or if symptoms worsen over time. **Initial: ____**

» I understand that any of these known side effects may occur and there is no way to predict who may experience them. **Initial _____**

» I understand that other unknown side effects may also occur following CoolSculpting® treatment, but elect to voluntarily proceed with CoolSculpting®. **Initial _____**

» No one associated with the medical practice or the manufacturer of CoolSculpting® has provided any information which contradicts any of the risks that have just been described. **Initial _____**

Results

» You may start to see changes in as early as 1-3 months after your CoolSculpting procedure. Your body will continue to naturally process the injured fat cells from your body for months after your procedure. **Initial: ____**

» Results vary from person to person. You may decide that additional treatments are necessary to achieve your desired outcome. Although highly unlikely, it is possible that you will not experience any noticeable result from the procedure. **Initial: ____**

» Particular results cannot be guaranteed, given that each body may react differently to stimuli. **Initial: ____**

Do you currently have or have had any of the following?

» Cryoglobulinemia (a condition in which an abnormal level of proteins thicken the blood in cold temperatures), or paroxysmal cold hemoglobinuria or cold agglutinin disease (blood disorders in which cold temperatures lead to red blood cell death). ……...**Yes / No**

» Known sensitivity to cold such as cold urticaria (hives triggered by cold), Raynaud's disease (disorder in which cold leads to reduced blood flow in the fingers, which appear white, red, or blue), pernio or Chilblains (itchy and/or tender red or purple bumps that occur as a reaction to cold). ……...**Yes / No**

» Poor blood flow in the area to be treated……...**Yes / No**

» Neuropathic (nerve) disorders such as post-herpetic neuralgia or diabetic neuropathy……...**Yes / No**

» Impaired skin sensation ……...**Yes / No**

» Open or infected wounds ……...**Yes / No**

» Bleeding disorders or use of blood thinners ……...**Yes / No**

» Recent surgery or scar tissue in the area to be treated……....**Yes / No**

» A hernia or history of hernia in the area to be treated or adjacent to treatment site ……...**Yes / No**

» Skin conditions such as eczema, dermatitis, or rashes……....**Yes / No**

» Pregnancy or lactation (making breast milk or breast feeding) ……...**Yes / No**

» Any active implanted devices such as pacemakers and defibrillators ……....**Yes / No**

» Any major health problems such as liver disease ……...**Yes / No**

» Any known sensitivity to fructose, glycerin, isopropyl alcohol (rubbing alcohol) or propylene glycol ……**Yes / No**

As with most medical procedures, there are risks and side effects. These have been explained to me in detail. I accept these risks by proceeding with this elective treatment. I have read the above information, and I give my consent to be treated with the CoolSculpting® procedure by the physician(s) in this practice and his/her designated staff.

Print Name: _____ Signature:_____ Date: _____

Witness
Print Name: _____Signature:_____ Date: _____

Physician(s): _____ Practice Name: _____

CSC120106-v2 12/19

Patient Consultation Form

coolsculpting

Patient Name _____ Weight _____

Consultation led by _____ Date _____

Allē℠ Member? Yes ☐ No ☐

Availability for treatments? (Check preferences)

M ☐ T ☐ W ☐ Th ☐ F ☐ Sa ☐

Morning ☐ Afternoon ☐ Evening ☐

Goals

Patient goal(s) and timeline (eg, special occasion in 3 months)

_____

_____

Assessment

Rank the top 3 areas where you would like to reduce fat and add lines to indicate these locations on the diagram:

_____ Under the Chin

_____ Under the Jawline

_____ Upper Arm

_____ Bra Area

_____ Back Fat

_____ Side (Flank)

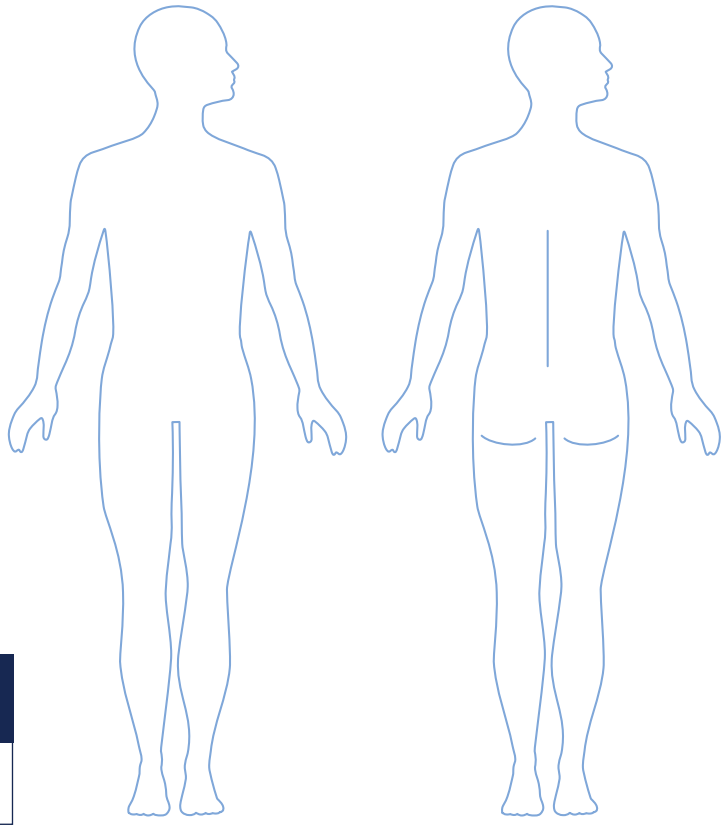
_____ Abdomen

_____ Underneath the Buttocks (Banana roll)

_____ Inner Thigh

_____ Outer Thigh

_____ Distal Thigh (Above the Knee)



Personalized Treatment Plan

Initial treatment area: _____

_____

Package Pricing

Sessions, Treatments, Pricing, and Points

Number of Sessions	Total Number of Treatments	Package Price	Allē Points
		$	

Uses

The CoolSculpting® procedure is FDA-cleared for the treatment of visible fat bulges in the submental (under the chin) and submandibular (under the jawline) areas, thigh, abdomen and flank, along with bra fat, back fat, underneath the buttocks (also known as banana roll) and upper arm. It is also FDA-cleared to affect the appearance of lax tissue with submental area treatments. The CoolSculpting® procedure is not a treatment for weight loss.

Important Safety Information

The CoolSculpting® procedure is not for everyone. You should not have the CoolSculpting® procedure if you suffer from cryoglobulinemia, cold agglutinin disease, or paroxysmal cold hemoglobinuria.

Tell your doctor if you have any medical conditions including recent surgery, pre-existing hernia, and any known sensitivities or allergies.

During the procedure you may experience sensations of pulling, tugging, mild pinching, intense cold, tingling, stinging, aching, and cramping at the treatment site. These sensations subside as the area becomes numb. Following the procedure, typical side effects include temporary redness,

Important Safety Information (Continued)

swelling, blanching, bruising, firmness, tingling, stinging, tenderness, cramping, aching, itching, or skin sensitivity, and sensation of fullness in the back of the throat after submental or submandibular area treatment.

Rare side effects may also occur. CoolSculpting® may cause a visible enlargement in the treated area which may develop two to five months after treatment and requires surgical intervention for correction.

Please see full Important Safety Information at coolsculpting.com

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an AbbVie company

Please refer to the Allergan® Privacy Statement at **www.allergan.com/privacy** and the California Privacy Policy at **www.allergan.com/privacy/ccpa**.

Patient Photography Release Form

Patient Name:

I, _____ , authorize my physician and staff representatives, to take photographs of my body for medical purposes to be used for my patient care, marketing, literature and/or case presentations.

I understand that:

- Photographs are taken to capture treatment outcomes for the CoolSculpting® procedure.
- They may be used for print, visual or electronic media including but not limited to, scientific presentations, websites and for purposes of informing the medical profession or general public about the procedure. These uses may also include marketing on behalf of the physician's practice.
- They may be released to Allergan and its corporate affiliates and may be used for print, visual or electronic media including but not limited to, scientific presentations, websites, general marketing, and for purposes of informing the medical profession or general public about the CoolSculpting® procedure.
- The images taken of me may be published by the physician, Allergan and their agents and representatives.
- I will not be identified by name in any of the published materials.
- My face will not be shown in the photographs nor will they reveal my identity.
- I have the right to revoke this authorization in writing at any time through a written revocation to my physician and Allergan.

I hereby release my physician, Allergan and its agents from any and all claims and demands arising out of, or in conjunction with, the use of the photographs.

I certify that I have read this release carefully and fully understand its terms.

If under 18, guardian or parent must sign.

Print Name: _____ Signature: _____ Date: _____

Witness: _____ Date: _____

CSC120105-v2 08/19