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**

CONSENT FOR TREATMENT

Refine Aesthetics

DERMAL FILLERS

Treatment with Juvederm and/or Restylane can smooth folds and wrinkles, add volume to the face/lips and contour facial features. Dermal fillers are injected into the skin with a very fine needle or use of a cannula. The products produce a natural volume under the wrinkle/skin/lip which is lifted up and smoothed out. The results can often be seen immediately. This consent is for on/off label use. Also consent gives permission to remove placed product if necessary.

RISKS/COMPLICATIONS

It has been explained to me that there are certain potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: Post treatment discomfort, swelling, redness, bruising, discoloration. Post treatment infection associated with any transcutaneous injection. Allergic reaction. Reactivation of Herpes (cold sores). Lumps, visible yellow, white patches in approximately 20% of cases. Granuloma formation. Localized necrosis and/or sloughing, with/without scabbing if blood vessel occlusion occurs. Failure to achieve the desired response.

PHOTOGRAPHS

I authorize the taking of clinical photographs and their use for before/after comparison, education, promotion, both in publication/ presentation. All photos show treated area only. I understand my identity will be protected. Under no circumstances will any publication, film photograph, video or material contain your name. I waive any rights for claims for payment or royalties in connection with any use of these photographs.

PREGNANCY, ALLERGIES, DISEASE

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 any of the above mentioned dermal fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine.

PAYMENT

I understand that this procedure is cosmetic and that payment is my responsibility.

RESULTS

I am aware that full correction is important and that follow-up/touch-up treatments will be needed to maintain the full effects. I am aware that the duration of treatment is dependent on many factors including but not limited to: Age, sex, tissue condition, my general health, lifestyle conditions, sun exposure and kind and amount of filler placed. The correction, depending on these factors may last anywhere from 6 - 24 months. I have been instructed in and understand post treatment instructions and have been given a copy of them.

I hereby voluntarily consent to treatment. The procedure has been explained to me. I have read the above and fully understand. My questions have been answered. I accept the risks and complications of the procedure. I certify that if I have any changes occur in my medical history I will notify Refine Aesthetics.

_____	_____	Judy Aker RN	_____
Patient Signature	Date	Witness Signature	Date