HEALTH HISTORY & INFORMED CONSENT FOR FACIAL ESTHETICS TREATMENT

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

Client Name_____ Date_____

Date of Birth_____ Age_____ Occupation_____

Home Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Email_____

What is the best number for you to receive a follow up call this evening? _____

Emergency Contact Name & Phone _____

How were you referred to us? _____

MEDICAL HISTORY

Are you currently under the care of a physician? ○ YES (Please indication what for) ○NO

_____

Do you have any of the following medical conditions? YES (Please indication below) NO

Cancer	Diabetes	High Blood Pressure	Herpes
Arthritis	Cold Sores	HIV/AIDS	Keloid scarring
Skin disease	Skin lesions	Seizure disorder	Uncontrolled muscle spasms
Hormone imbalance	Thyroid imbalance	Excessive sweating	Any active infection
Heart Conditions	Pregnant/trying/lactating	Breastfeeding	Using birth control
Parkinson's	Myasthenia Graves	Multiple Sclerosis	Lambert-Eaton Syndrome
Lou Gehrig's (ALS)	Headaches	Hepatitis	Blood clotting abnormalities
Blurred/double vision	Trouble breathing	Difficulty swallowing	Clenching/grinding

Any other health conditions not listed above? _____

What oral prescription medications are you presently taking? _____

What antibiotics do you use to treat infections? Any allergies to antibiotics?

_____

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

*Anticoagulant blood thinning effects

*Aspirin	Blood thinners	Hormones	Mood altering medication
*COQ10	Vitamin E	Fish Oil	Omega 3 Fatty Acids
Cayenne	Garlic	*Ginger	*Ginkgo biloba
*Licorice	Flax seed oil	*Clove	Anti-depression medication

Have you ever had an allergic reaction to the following?

Food	Animal	Protein	Lidocaine (Anesthetic)
Hydrocortisone	Eggs	Latex	Hydroquinone
Skin bleaching agents	Others		

If yes please list: _____

_____

HEALTH HISTORY & INFORMED CONSENT FOR FACIAL ESTHETICS TREATMENT

CHIEF COMPLAINT(S)

1) Please describe your chief concerns and what you are seeking treatment for (cosmetically or otherwise)?

_____

_____

_____

FACIAL HISTORY

1) What bothers you most about your facial appearance? _____

_____

2) What are your expectations for today's visit? _____

_____

3) Do you regularly sun bathe or use tanning salons?_____If so, how often? _____

4) What topical medications or creams are you currently using? RetinA Other (Please list):

_____

5) Have you waxed, tweezed, bleached or used hair removal cream within the last week? YES / NO If yes, please specify:

_____

6) Have you ever had botox, dermal fillers, solid filler PDO threads, Sculptra, Kybella? YES / NO
If yes, when were you last treated:_____
Any complications? YES / NO If yes, please specify_____

7) Have you taken any Aspirin, Ibuprofen, Motrin, Tylenol, Fish Oil, Vitamin E, Blood Thinners, or Alcoholic Beverages in the last ten days? YES / NO If yes, what?

_____

FACIAL INJURY TRAUMA HISTORY

1) Is there any history of facial surgery? YES / NO If yes, please describe:

_____

2) Any TMJ problems? Pain/clenching/grinding? YES / NO If yes, please describe:

_____

3) Do you have any history of falls, accidents, or injuries (auto accident, sports injuries, facial impacts) to the face, neck, back or head? YES / NO If yes, please explain:

_____

4) Is there any activity which holds the head or jaw in an imbalanced position (Instrument, phone, swimming)?

_____

5) Have you had any major dental treatment in the last two years? YES / NO If yes, please circle procedure(s) below:

Braces or aligners Periodontics Oral Surgery Restorative

Dates of any circled above: _____

INFORMED CONSENT FOR BOTULINUM TOXIN & TRIGGER POINT 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 as 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 you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

BOTULINUM TOXIN TREATMENT

Botulinum toxin (Botox®, Xeomin®) is a neurotoxin produced by the bacterium Clostridium A. Botulinum toxin can relax the muscles on areas of the face and neck which cause wrinkles associated with facial expressions or facial pain. Treatment with botulinum toxin can cause your facial expression lines or wrinkles to be less noticeable or essentially disappear. Areas most frequently treated are: a) glabellar area of frown lines, located between the eyes; b) crow's feet (lateral areas of the eyes); c) forehead wrinkles; d) radial lip lines (smokers lines), e) head and neck muscles. Botulinum toxin can also be used to treat parafunctional clenching, extracapsular myogenic temporomandibular disorder, trismus, and the associated headaches. Botox is diluted to a very controlled solution and when injected into the muscles with a very thin needle, it is almost painless. Patients may feel a slight burning sensation while the solution is being injected. The procedure takes about 15-20 minutes and the results can last up to 3 months. With repeated treatments, the results may tend to last longer. **Initial_____**

TRIGGER POINT THERAPY TREATMENT

Trigger point injections (TPI) is used to treat extremely painful and tender areas of muscles. Normal muscle contracts and relaxes wen it is active. A trigger point is a knot or tight bend in the muscle that forms when muscle fails to relax. The knot often can be felt under the skin and may twitch involuntarily when touched (called a jump sign). The trigger point can trap or irritate surrounding nerves and cause referred pain- pain felt in another part of the body or in the teeth. Scar tissue and loss of range of motion and weakness may form over time. A small needle is inserted into the trigger point and a local anesthetic (e.g., lidocaine, procaine), botulinum toxin (e.g. Botox) or anti-inflammatory steroid is injected. Trigger point injections have been found to be very effective in relieving pain, and may be used in combination with home exercise, heat, cold, and an individualized medication program. **Initial_____**

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 extended 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, and bruising, tingling, or numbness, 2.) Double vision, 3.) A weakened tear duct, 4.) Post treatment bacterial, and/ or fungal infection requiring further treatment, 5.) Allergic reaction, 6. Minor temporary droop of eyelid(s) and/or Bell's Palsy in approximately 2% of injections, this usually lasts 2-3 weeks, 7.) Occasional numbness of the forehead lasting up to 2-3 weeks, 8.) Transient headache , 9.) Flu- like symptoms, 10.) Palpatations. **Initial_____**

PREGNANCY, ALLERGIES & NEUROLOGIC DISEASE

I am not aware that I am pregnant and I am not trying to get pregnant, I am not lactating (nursing). I do not have any significant neurologic disease including but not limited to myasthenis gravis, multiple sclerosis, lambert-eaton syndrome, amyotrophic lateral sclerosis (ALS), and parkinson's. I do not have any allergies to the toxin ingredients, or to human albumin. **Initial** _____

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that I have volunteered for have been fully explained to me. To include but not limited to an occlusal guard and/or seeking out a specialist. **Initial_____**

PAYMENT

I understand that this is an "elective" procedure. As such, payment is my responsibility and is expected at the time of treatment. **Initial** _____

RIGHT TO DISCONTINUE TREATMENT

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

INFORMED CONSENT FOR BOTULINUM TOXIN & TRIGGER POINT TREATMENT

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. I understand that photographs and video may be taken of me for educational and marketing purposes. I hold the Dr. Roberts harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs. **Initial_____**

RESULTS FOR BOTULINUM TOXIN

I am aware that when small amounts of purified botulinum toxin are injected into a muscle it causes weakness or paralysis of that muscle. This appears in 2 – 10 days and usually lasts up to 3 months but can be shorter or longer. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual and there are some individuals who do not respond at all. I understand that I will not be able to use the muscles injected as before while the injection is effective but that this will reverse after a period of months at which time re- treatment is appropriate. I understand that I must stay in the erect posture and that I must not manipulate the area (s) of the injections for the 2 hours post-injection period. **Initial_____**

RESULTS FOR TRIGGER POINT THERAPY

You may receive the following benefits. The doctors cannot guarantee you will receive any of these benefits. Only you can decide if the benefits are with the risk. Trigger point injections is used to alleviate myofascial pain syndrome (chronic pain involving tissue that surrounds muscle) that does not respond to other treatments, although there is some debate over its effectiveness. Many muscle groups, especially those in the arms, legs, lower back, and neck, are treated by this method. Trigger point injections can also be used to treat fibromyalgia, tension headaches, TMJ dysfunction, and other types of orofacial pain. I understand this is an elective procedure and I hereby voluntarily consent to treatment with trigger point injections for TMJ dysfunction, bruxism and types of orofacial pain including headaches and migraines 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 treatment me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I 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. **Initial_____**

I understand this is an elective procedure and I hereby voluntarily consent to treatment with botulinum toxin injections for facial dynamic wrinkles, TMJ dysfunction, bruxism and types of orofacial pain including headaches and migraines. 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 it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I 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.

Patient Name (Print)	Patient Signature	Date

I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

Doctor Name (Print)	Doctor Signature	Date

INFORMED CONSENT FOR DERMAL FILLER 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 as 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 you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

DERMAL FILLER TREATMENT

Treatment with dermal fillers (such as Juvederm, Restylane, Radiesse, Revanesee, 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. **Initial_____**

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 extended 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. **Initial** _____

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

Alternatives to the procedures and options that I have volunteered for have been fully explained to me. **Initial** _____

PAYMENT

I understand that this is an "elective" procedure. As such, payment is my responsibility and is expected at the time of treatment. **Initial** _____

RIGHT TO DISCONTINUE TREATMENT

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

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. I understand that photographs and video may be taken of me for educational and marketing purposes. I hold the Dr. Roberts harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs. **Initial** _____

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 6 months. Most patients are pleased with the results of dermal fillers use. However, like any esthetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatment to achieve the results you seek. The dermal filler procedure is temporary and additional treatments will be required periodically, generally within 4-6 months, 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 many factors including 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 6 months and in some cases shorter and some cases longer. I have been instructed in and understand the post-treatment instructions. **Initial** _____

INFORMED CONSENT FOR DERMAL FILLER TREATMENT

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 it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I 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.

Patient Name (Print)	Patient Signature	Date

I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

Doctor Name (Print)	Doctor Signature	Date

INFORMED CONSENT FOR PDO THREAD LIFT & SMOOTHING 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 as 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 you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

PDO (POLYDIAXONONE) THREAD LIFT AND SMOOTHING TREATMENT

The PDO (polydiaxonone) Thread Lift and Smoothing procedure uses absorbable surgical sutures placed into the subdermal layer of the skin to initiate collagen production. The procedure can result in increased firmness and elasticity of the skin in the treated area. The nature of cosmetic procedure may require a patient to return for numerous visits in order to achieve the desired results or to determine whether the treatment may not be completely effective at treating the particular condition.

RISKS AND COMPLICATIONS

You have been informed on some of the features, benefits, and possible risks involved with solid filler PDO thread lifting and smoothing, and have had your questions answered to your satisfaction. Some of the possible risks include:

- **Discomfort:** Some discomfort may be experienced during treatment. **Initial** ____
- **Scarring:** May cause scarring; sutures are inserted using a small needle, which must heal. A scar at entry point may occur. **Initial** ____
- **Bruising, Swelling, Infection:** With any minimally invasive procedure, bruising of the treat area may occur along with the potential for swelling and is likely. Infection is rare, but with any injection or incision into the skin, the possibility exists. **Initial** ____
- **Bleeding:** You may experience some bleeding during the procedure. Hematoma or a small blood clot may occur and may require treatment by drainage. There is a higher risk of bleeding if you have taken any anti-inflammatory medications (Advil, Motrin, Aspirin, Ibuprofen) within the 10 days preceding the procedure. **Initial** ____
- **Damage to Deeper Structures:** Deeper structures such as nerves, blood vessels and muscles may be damaged during the procedure. The potential for this to occur varies according to the location on the body the procedure is being performed. Injury to deeper structures may be temporary or permanent. **Initial** ____
- **Allergic Reaction:** Allergies to tape, suture material or topical preparations have been reported. Allergic reactions may require additional treatment. **Initial** ____
- **Partial Laxity Correction:** PDO Lift may not correct all your facial laxity or sagging. **Initial** ____
- **Delay Healing:** Complications may ensure as a result of smoking, using a straw, or similar motions. Smoking and similar actions are STRONGLY discouraged. Slight asymmetry, redness, visible sutures, suture breakthrough may require additional treatment or removal of the sutures. **Initial** ____

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 solid filler PDO threads. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine. **Initial** _____

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that I have volunteered for have been fully explained to me. **Initial** _____

PAYMENT

I understand that this is an "elective" procedure. As such, payment is my responsibility and is expected at the time of treatment. **Initial** _____

RIGHT TO DISCONTINUE TREATMENT

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

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. I understand that photographs and video may be taken of me for educational and marketing purposes. I hold the Dr. Roberts harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs. **Initial** _____

RESULTS

I understand this is an elective procedure and I hereby voluntarily consent to treatment with PDO suture threads for skin rejuvenation, lifting of the skin to help establish proper lip and smile lines and improved esthetics. 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 it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I 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. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatment to achieve the results you seek. The solid filler PDO thread procedure is temporary and additional treatments will be required periodically, generally within 12-18 months although not guaranteed, involving additional placement of PDO threads 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 many factors including 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 18 months and in some cases shorter and some cases longer. I have been instructed in and understand the post-treatment instructions. **Initial** _____

Patient Name (Print)	Patient Signature	Date

I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

Doctor Name (Print)	Doctor Signature	Date

INFORMED CONSENT FOR SCULPTRA 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 as 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 you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

SCULPTRA INJECTABLE POLY-L-LACTIC ACID TREATMENT

Sculptra is a sterile suspension of Poly-L-Lactic acid, which is a biocompatible (does not harm the body), synthetic polymer from the alpha-hydroxy acid family (fruit acids). Sculptra has been used since 1999 in more than 150,000 patients in more than 30 countries, Poly-L-Lactic acid has been used medically for many years primarily for cosmetic use and in dissolvable stitches. Sculptra is designed to help correct skin depression, such as creases, wrinkles, folds, scars, hollow eye rings, skin aging, and facial lip-atrophy (loss of fat).

RISKS AND DISCOMFORT

You have been informed on some of the features, benefits, and possible risks involved with Sculptra and have had your questions answered to your satisfaction. Some of the possible risks include:

- After the injection(s), some common injection-related reactions probably will occur. These may include swelling, redness, pain, itching, discoloration and tenderness at the injection site. These typically resolve spontaneously, usually within 1 to 15 days after injection. **Initial**_____
- Because Sculptra is injected in a solution containing water, there will be an initial swelling (edema) that will be noticeable for at least several hours and perhaps as long as several days. This effect is temporary and does not affect the long-term tissue response. **Initial**_____
- Induration, or a feeling of fullness or thickness, can be felt in the injection areas. This is a normal response of the treated tissue to the process of inflammation and new collagen formation. Simply massaging the treated areas gently 5 times per day for 5 minutes after the injection can help minimize induration. **Initial**_____
- One possible delayed side effect is small bumps under the skin, termed micro-nodules, which may be non-visible or visible and may be felt in the areas of treatment. Usually these bumps may only be felt when pressing on the skin. Micro-nodules tend to occur within the first 6 to 12 months after the treatment. They usually do not require treatment and usually do not have any symptoms. **Initial**_____
- Visible bumps may occur in rare instances and they be associated with redness, tenderness, skin discoloration or textural alteration. These bumps, which may be termed granuloma, may or may not require treatment, including, but not limited to, injection, freezing or excision. **Initial**_____
- Other rarely reported adverse events include: injection site abscess, allergic reaction, skin hypertrophy (exaggerated reduction of collagen and tissue elasticity) and/or atrophy (reduction of collagen and tissue elasticity), malaise, fatigue and swelling (edema). **Initial**_____
- The use of anti-inflammatory drugs, anti-clotting agents or aspirin might cause bleeding or increased bruising at the injection site. **Initial**_____

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 Sculptra. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine. **Initial** _____

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that I have volunteered for have been fully explained to me. **Initial** _____

PAYMENT

I understand that this is an "elective" procedure. As such, payment is my responsibility and is expected at the time of treatment. **Initial** _____

RIGHT TO DISCONTINUE TREATMENT

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

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. I understand that photographs and video may be taken of me for educational and marketing purposes. I hold the Dr. Roberts harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs. **Initial** _____

RESULTS

Depending on the area and condition treated as well as the volume of Sculptra used in the injection, the effect of a treatment with Sculptra may

last from 1 to 2 years, but that in some cases the duration of the effect can be shorter or longer. Most areas of treatment will require multiple sessions at 4 week intervals, for optimal correction. Because individual response to Sculptra may vary, the exact number of treatments sessions required cannot be predicted with complete accuracy. Additionally, in order to maintain the desired degree of correction, intermittent enhancement treatments may be needed. **Initial**_____

I understand this is an elective procedure and I hereby voluntarily consent to treatment for facial rejuvenation, 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 it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I 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. **Initial**_____

Patient Name (Print)	Patient Signature	Date

I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

Doctor Name (Print)	Doctor Signature	Date

INFORMED CONSENT FOR KYBELLA 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 as 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 you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

KYBELLA (DEOXYCHOLIC ACID) TREATMENT

Kybella (deoxycholic acid) injection is indicated for improvement in the appearance of moderate to severe fullness associated with submental fat, also called “double chin,” in adults. Kybella is injected into the fat under the chin as well as other areas of superficial fat for fat removal. Multiple treatments are usually required and will be given at least 1 month apart.

RISKS AND COMPLICATIONS

Common potential side effects include swelling, bruising, pain, numbness, redness and areas of hardness in the treatment area Kybella injections can also cause tingling, nodule, itching, skin tightness and headache. These side effects typically resolve themselves without treatment and do not usually result in patients stopping treatment.

Less common potential side effects include: nerve injury – Kybella injections could cause nerve injury in the area of the jaw resulting in an uneven smile or facial muscle weakness. In the clinical trials these all resolved without treatment and do not usually result in patients stopping treatment in an average of 6 weeks. Kybella injections can temporarily cause trouble with swallowing (this is thought to be due to neck swelling), superficial skin erosions and small patches of hair loss in the beard area. There is a possibility of an unsatisfactory result. The procedure may also result in more noticeable platysma bands, unacceptable visible deformities or asymmetry in the treatment area. **Initial** _____

PREGNANCY AND ALLERGIES

It is not known if Kybella will harm an unborn baby. It is not known if Kybella passes into your breast milk. 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 Kybella. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine. **Initial** _____

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that I have volunteered for have been fully explained to me. **Initial** _____

PAYMENT

I understand that this is an "elective” procedure. As such, payment is my responsibility and is expected at the time of treatment. **Initial** _____

RIGHT TO DISCONTINUE TREATMENT

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

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. I understand that photographs and video may be taken of me for educational and marketing purposes. I hold the Dr. Roberts harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs. **Initial** _____

RESULTS

Depending on the amount of submental fat, multiple treatments may be required and will be spaced 1 month apart. Most individuals will require multiple sessions at 4 week intervals, for optimal correction. Because individual response to Kybella may vary, the exact number of treatments sessions required cannot be predicted with complete accuracy. Additionally, in order to maintain the desired degree of correction, intermittent enhancement treatments may be needed. Additional treatments may also be required for the correction of skin laxity following removal of underlying submental fat. **Initial**_____

Before receiving Kybella patients should tell their doctor/healthcare provider about all of their medical conditions, including if they: have an infection in the treatment area; have had or plan to have surgery on the face, neck or chin; have had cosmetic treatments on the face, neck or chin; have had or have medical conditions in or near the neck area; have had or have trouble swallowing; have bleeding problems or are taking blood thinners; are pregnant or plan to become pregnant.

INFORMED CONSENT FOR KYBELLA TREATMENT

I understand this is an elective procedure and I hereby voluntarily consent to treatment for facial rejuvenation, establish proper lip and smile lines, and eliminating fat. 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 it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I 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. There is no guarantee that submental excess fat will disappear completely, or that you will not require additional treatment to achieve the results you seek. The Kybella procedure is temporary and additional treatments may be required periodically for the effect to continue. I am aware that follow-up treatments may be needed to maintain the full effects. I am aware the duration of treatment is dependent on many factors including 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 18 months and in some cases shorter and some cases longer. I have been instructed in and understand the post-treatment instructions.
Initial _____

Patient Name (Print)	Patient Signature	Date

I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

Doctor Name (Print)	Doctor Signature	Date

BoNT-A Cosmetic MEDICATION GUIDE

Due to the fact that there are now multiple Botulinum Toxin, Type A products on the market, the FDA has required that all Botulinum toxin, Type A products carry a black box warning label to alert the public of possible adverse reactions or side effects of the toxins, as well as proper use of the toxins, and risk factors associated with there use. This is due to the fact that not all Botulinum toxins are created equal, and the public has a right to be made aware of the differences associated with each toxin that is available to you for injection. The 3 Botulinum toxins available in the USA are Botox®, Dysport®, and Xeomin®. This form is the black box warning that is now required to be present on package inserts. It is important to note that all BoNT-A products are required by the FDA to include the black box warning on package inserts. Please read the following form, which is the black box warning now on all package inserts of Botox®, Dysport®, and Xeomin® and sign the bottom stating we have made you aware of these new requirements by the FDA. I have received a copy of the MEDICATION GUIDE for XEOMIN® Cosmetic for Injection. **Initial if true** _____

Patient Signature:_____Date:_____

Witness: _____

Dr. _Shannon Roberts, DDS_____Signature: _____

Diagnosis and Treatment Plan - Botox

Patient Information

Patient Name:_____ Date:_____

Treating Doctor Name: _____

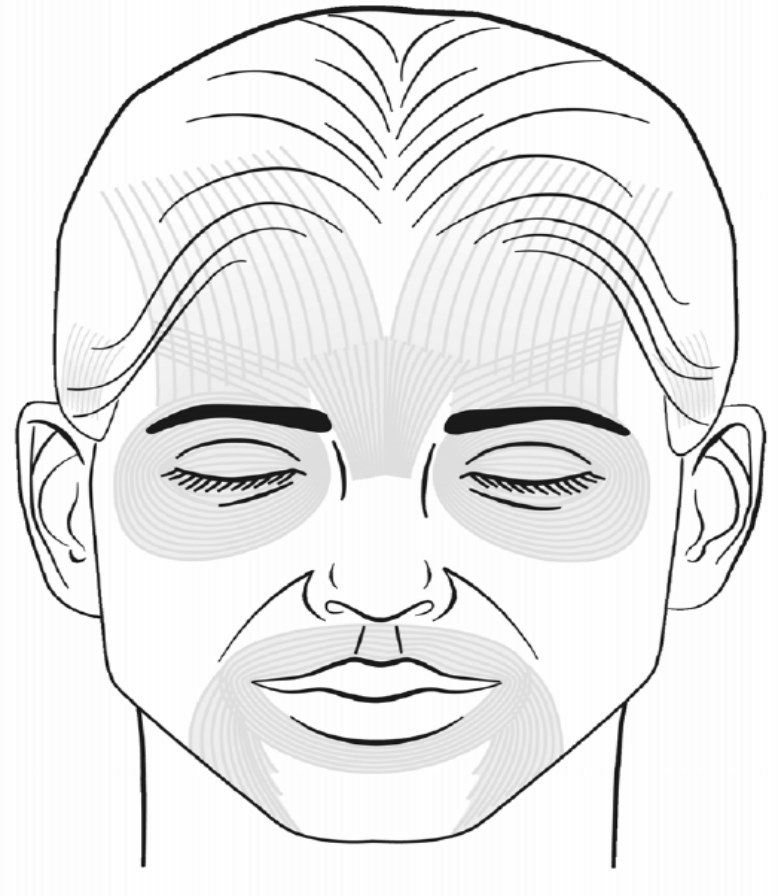
Health History Completed? Yes □ No □ Date:_____ Doctor Initial: _____

Dental / Head and Neck Examination Completed? Yes □ No □ Date:_____ Doctor Initial: _____

Informed Consent Completed? Yes □ No □

Diagnosis ICD-10 Codes (Check all that apply)

- □ K03.0 Excessive attrition
- □ K03.81 Cracked tooth
- □ K06.0 Gingival recession
- □ M26.00 Anomalies of jaw size
- □ M26.11 Maxillary asymmetry
- □ M26.12 Jaw asymmetry
- □ M26.52 Orofacial dyskinesia
- □ M26.53 Limited range of motion
- □ M26.53 Deviation opening closing
- □ M26.50 Dentofacial abnormal fx
- □ K08.109 Loss of teeth
- □ M26.60 TMJ disorders
- □ M26.63 TMJ disc disorder (reducing/non-reducing)
- □ M26.69 TMJ sounds opening/closing jaw
- □ M26.9 Dentofacial anomalies
- □ K13.0 Diseases of lips
- □ K13.70 Cheek/Lip biting
- □ K08.419 Loss of teeth trauma
- □ G47.63 Sleep related bruxism
- □ M62.40 Muscle spasm
- □ G50.1 Atypical facial pain
- □ R25.0 Trismus
- □ M79.1 Myalgia
- □ M60.9 Myofascial pain
- □ M79.2 Neuralgia, neuritis, facial
- □ S03.4XXA Jaw sprain
- □ G44.209 Tension headache
- □ G43.109 Migraine with aura
- □ G43.009 Migraine without aura
- □ G43.811 Cluster headache
- □ R51 Headache
- □ F45.8 Bruxism
- □ G50.0 Trigeminal neuralgia
- □ _____ Other



Muscle	Dosage (in units)	Syringe Volume
Frontalis		
Glabella		
(R) Orbicularis oculi		
(L) Orbicularis oculi		
Nasalis		
Orbicularis Oris		
(R) DAO		
(L) DAO		
Platysma		
(R) Temporalis		
(L) Temporalis		
(R) Masseter		
(L) Masseter		
(R) Occipitalis		
(L) Occipitalis		

Total units needed: _____

Diagnosis and Treatment Plan – Dermal Fillers & PDO Thread

Patient Information

Patient Name:_____ Date:_____

Treating Doctor Name: _____

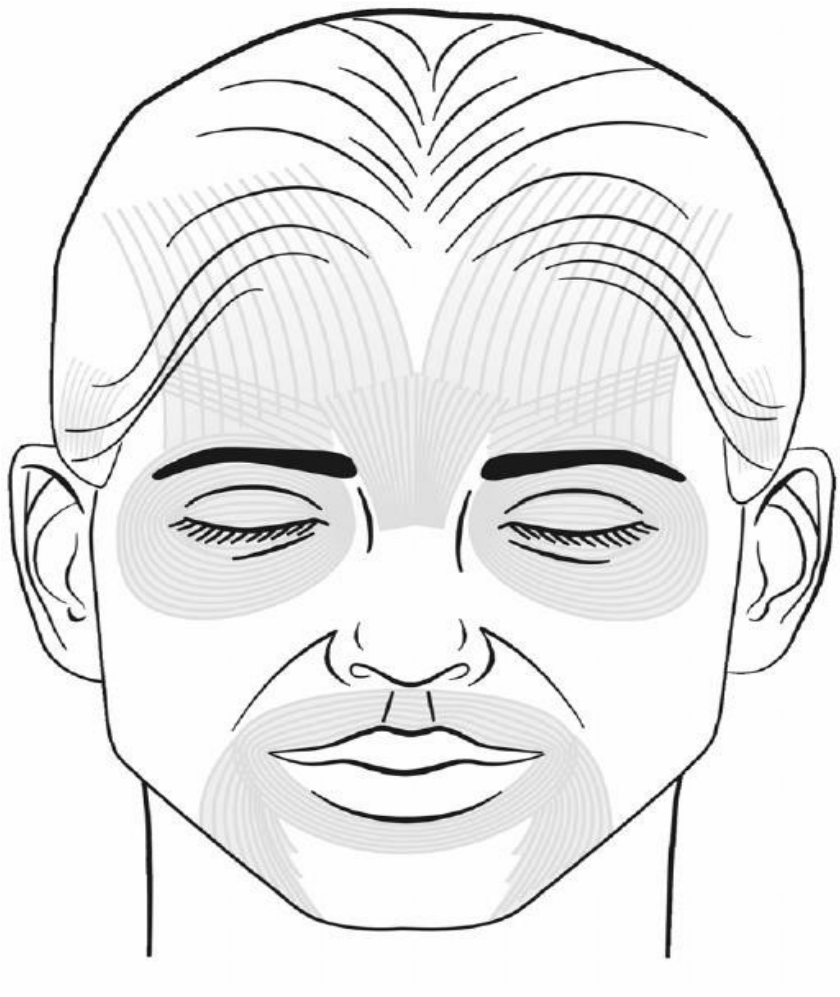
Health History Completed? Yes □ No □ Date:_____ Doctor Initial: _____

Dental / Head and Neck Examination Completed? Yes □ No □ Date:_____ Doctor Initial: _____

Informed Consent Completed? Yes □ No □

Diagnosis ICD-10 Codes (Check all that apply)

□ K03.0 Excessive attrition
□ K03.81 Cracked tooth
□ K06.0 Gingival recession
□ M26.00 Anomalies of jaw size
□ M26.12 Maxillary asymmetry
□ K08.109 Loss of teeth
□ M26.9 Dentofacial anomalies
□ K13.0 Diseases of lips
□ S01.551 Cheek/Lip biting
□ K08.419 Loss of teeth trauma
□ M26.12 Jaw asymmetry
□ M26.50 Dentofacial abnormal funct
□ _____ Other
□ _____ Other
□ _____ Other



Muscle	Filler Used	Volume Used ml
(R) Nasolabial Fold		
(L) Nasolabial Fold		
(R) Marionette Line		
(L) Marionette Line		
Upper Lip		
Lower Lip		
(R) Oral Commissure		
(L) Oral Commissure		
Philturm		
(R) Cheek		
(L) Cheek		
Kybella		
Sculptra		
Face Lifting		
Neck Lifting		
Face Smoothing		
Neck Smoothing		

Total volume used: _____

Total lifting threads used: _____

Total smoothing threads used: _____

Pre-Treatment Instructions

In an ideal situation it is prudent to follow some simple guidelines before treatment that can make all the difference between a fair result or great result, by reducing some possible side effects associated with the injections. We realize this is not always possible however, minimizing these risks is always desirable.

- Do NOT consume alcoholic beverages at least 24 hours prior to treatment (alcohol may thin the blood and increase the risk of bruising)
- Avoid anti-inflammatory/blood thinning medications, if possible, for a period of 2 weeks before treatment. Medications and supplements such as Cod Liver Oil, Flax Seed Oil, Garlic, Ginkgo Biloba, Ginseng, St. John's Wort, Omega 3/Fish Oil supplements, Vitamin A&E, Advil, Aleve, Aspirin, Ibuprofen, Motrin, Vioxx and other NSAIDS have a blood thinning effect and can increase the risk of bruising and swelling after injections.
- AVOID: Alcohol, caffeine, Niacin supplement, high-sodium foods, high sugar foods, refined carbohydrates (you may eat fruit), spicy foods, and cigarettes 24-48 hours before and after your treatment
- Schedule your Dermal Filler and Botulinum toxin appointment at least 2-4 weeks prior to a special event which you may be attending, such as a wedding or a vacation. Results from the Dermal Filler and Botox injections will take approximately 2 to 14 days to appear. Also bruising and swelling may be apparent in that time period.
- Discontinue Retin-A (2) days before and (2) days after treatment.
- Reschedule your appointment at least 24 hours in advance if you have a rash, cold sore or blemish on the area.
- If you have a history of cold sores, please let your provider know as they may put you on an anti-viral medication prior to treatment.
- Be sure to have a good breakfast, including food and drink before your procedure. This will decrease the chances of lightheadedness during your treatment.
- You are not a candidate if you are pregnant or breastfeeding.

Post-Treatment Instructions for Botulinum Toxin

The guidelines to follow post treatment have been followed for years, and are still employed today to prevent the possible side effect of ptosis (drooping of the eyelids). These measures should minimize the possibility of ptosis.

- No straining, heavy lifting, vigorous exercise for 3-4 hours following treatment. It is now known that it takes the toxin approximately 2 hours to bind itself to the nerve to start its work, and because we do not want to increase circulation to that area to wash away the Botox from where it was injected.
- Do NOT manipulate the treated area for 3-4 hours following treatment. Do NOT receive facial/laser treatments, microdermabrasion, or peel after Botox injections for at least 10 days. Ask your provider if you are not sure about the time frame of certain services.
- Facial exercises in the injected areas is recommended for 1-2 hour(s) following treatment. This is to stimulate the binding of the toxin only to the localized area.
- Do NOT lie down for 4 hours after your Botox treatment. This will prevent the Botox from tracking into the orbit of your eye and causing drooping eyelid.
- It can take approximately 2 to 14 days for results to be seen. If the desired result is not seen after 2 weeks of your treatment you may need additional Botulinum Toxin. You are charged for the amount of product used. Therefore, you will be charged for a product used during any enhancements or subsequent appointments.
- Make-up may be applied prior to leaving the office.

Post-Treatment Instructions for Dermal Fillers & PDO Threads

The guidelines to follow post treatment have been followed for years, and are still employed today to prevent the possible side effect of dermal filler migration or distortion. These measures should minimize the possibility of negative outcomes associated with dermal fillers.

- DO NOT touch, press, rub or manipulate the implanted areas for the rest of the day after treatment. Avoid kissing, puckering and sucking movements for the rest of the day as these motor movements can undesirably displace the implanted dermal filler material. You can cause irritation, sores, and/or problems, and possible scarring if you do.
- No straining, heavy lifting, vigorous exercise, sun and/or heat exposure for 3 days following treatment.
- DO NOT receive facial/laser treatments, microdermabrasion, or peel after Botox injections for at least 10 days. Ask your provider if you are not sure about the time frame of certain services.
- Avoid anti-inflammatory/blood thinning medications, if possible, for a period of at least 3 days after treatment. Medications and supplements such as Cod Liver Oil, Flax Seed Oil, Garlic, Ginkgo Biloba, Ginseng, St. John's Wort, Omega 3/Fish Oil supplements, Vitamin A&E, Advil, Aleve, Aspirin, Ibuprofen, Motrin, Vioxx and other NSAIDS have a blood thinning effect and can increase the risk of bruising and swelling after injections.
- AVOID: Alcohol, caffeine, Niacin supplement, high-sodium foods, high sugar foods, refined carbohydrates (you may eat fruit), spicy foods, and cigarettes 24-48 hours before and after your treatment
- Discontinue Retin-A (2) days before and (2) days after treatment.
- Do NOT lie down for 4 hours after your dermal filler treatment. This will prevent the dermal filler from migrating away from the injected area or distorting into an undesirable esthetic place.
- It can take approximately 14 days for results to be seen. If the desired result is not seen after 2 weeks of your treatment you may need additional Dermal Filler. You are charged for the amount of product used. Therefore, you will be charged for a product used during any enhancements or subsequent appointments.
- Make-up may be applied 24 hours following treatment. Earlier application can cause pustules.
- One side may heal faster than the other side.
- You can expect some bruising and swelling around the areas that were injected. Apply ice for the first hour after treatment for ten minutes on and ten minutes off.
- Sleep with pillows or in a recliner chair for the first 48 hours following treatment to prevent migration of filler or thread.

*****Please report any redness, blisters, or itching immediately if it occurs after treatment.*****

I certify that I have been counseled in post-treatment instructions and have been given written instructions as well.

_____ _____

Patient Signature Date

MEDICATION GUIDE
XEOMIN® (Zeo-min)
(incobotulinumtoxinA) for injection, for intramuscular or intraglandular use

What is the most important information I should know about XEOMIN?
XEOMIN may cause serious side effects that can be life-threatening. Call your doctor or get medical help right away if you have any of these problems after treatment with XEOMIN:

Problems with swallowing, speaking, or breathing. These problems can happen hours to weeks after an injection of XEOMIN if the muscles that you use to breathe and swallow become weak after the injection. Death can happen as a complication if you have severe problems with swallowing or breathing after treatment with XEOMIN.
People with certain breathing problems may need to use muscles in their neck to help them breathe. These people may be at greater risk for serious breathing problems with XEOMIN.
Swallowing problems may last for several months. People who cannot swallow well may need a feeding tube to receive food and water. If swallowing problems are severe, food or liquids may go into your lungs. People who already have swallowing or breathing problems before receiving XEOMIN have the highest risk of getting these problems.

Spread of toxin effects. In some cases, the effect of botulinum toxin may affect areas of the body away from the injection site and cause symptoms of a serious condition called botulism. The symptoms of botulism include:
loss of strength and muscle weakness all over the body
double vision
blurred vision and drooping eyelids
- hoarseness or change or loss of voice
- trouble saying words clearly
- loss of bladder control
- trouble breathing
- trouble swallowing These symptoms can

happen hours to weeks after you receive an injection of XEOMIN.
These problems could make it unsafe for you to drive a car or do other dangerous activities. See **"What should I avoid while receiving XEOMIN?"**

What is XEOMIN?
XEOMIN is a prescription medicine used in adults:
that is injected into glands that make saliva and is used to treat long-lasting (chronic) drooling (sialorrhea).
that is injected into muscles and used to:
treat increased muscle stiffness in the arm because of upper limb spasticity.
treat the abnormal head position and neck pain with cervical dystonia (CD) in adults who have and have not had prior treatment with botulinum toxin.
treat abnormal spasm of the eyelids (blepharospasm) in adults who have had prior treatment with onabotulinumtoxinA (BOTOX).
improve the look of moderate to severe frown lines between the eyebrows (glabellar lines) for a short period of time (temporary).
It is not known if XEOMIN is safe and effective in children under 18 years of age.

Do not take XEOMIN if you:
are allergic to XEOMIN or any of the ingredients in XEOMIN. See the end of this Medication Guide for a list of ingredients in XEOMIN.
had an allergic reaction to any other botulinum toxin products such as rimabotulinumtoxinB (MYOBLOC), onabotulinumtoxinA (BOTOX, BOTOX COSMETIC), or abobotulinumtoxinA (DYSPORT).
have a skin infection at the planned injection site.

Before receiving XEOMIN, tell your doctor about all of your medical conditions, including if you:
have a disease that affects your muscles and nerves (such as amyotrophic lateral sclerosis [ALS or Lou Gehrig's disease], myasthenia gravis or Lambert-Eaton syndrome). See **"What is the most important information I should know about XEOMIN?"**
have had any side effect from any other botulinum toxin in the past.
have a breathing problem, such as asthma or emphysema.
have a history of swallowing problems or inhaling food or fluid into your lungs (aspiration).
have bleeding problems.
have drooping eyelids.
plan to have surgery.
have had surgery on your face.
are pregnant or plan to become pregnant. It is not known if XEOMIN can harm your unborn baby.
are breastfeeding or plan to breastfeed. It is not known if XEOMIN passes into your breast milk.

Tell your doctor about all the medicines you take, including prescription and over-the-counter medicines, vitamins and herbal supplements. **Talk to your doctor before you take any new medicines after you receive XEOMIN.**

Using XEOMIN with certain other medicines may cause serious side effects. **Do not start any new medicines until you have told your doctor that you have received XEOMIN in the past. Especially tell your doctor if you:**

have received any other botulinum toxin product in the last four months.

- have received injections of botulinum toxin such as rimabotulinumtoxinB (MYOBLOC), onabotulinumtoxinA (BOTOX, BOTOX COSMETIC) or abobotulinumtoxinA (DYSPORT) in the past. Be sure your doctor knows exactly which product you received. The dose of XEOMIN may be different from other botulinum toxin products that you have received.

have recently received an antibiotic by injection or inhalation.
take muscle relaxants.
take an allergy or cold medicine.
take a sleep medicine.
Ask your doctor if you are not sure if you take any of the medicines listed above.

Know the medicines you take. Keep a list of your medicines with you to show your doctor and pharmacist each time you get a new medicine.

How will I receive XEOMIN?

XEOMIN is a shot (injection) that your doctor will give you.
XEOMIN is injected into your affected muscles or glands.
Your doctor may change your dose of XEOMIN during treatment.

What should I avoid while taking XEOMIN?

XEOMIN may cause loss of strength or general muscle weakness, blurred vision, or drooping eyelids within hours to weeks of taking XEOMIN. **If this happens, do not drive a car, operate machinery, or do other dangerous activities.**
See **"What is the most important information I should know about XEOMIN? "**

What are the possible side effects of XEOMIN? XEOMIN may cause serious side effects, including:
See "What is the most important information I should know about XEOMIN?"

Injury to the cornea (the clear front surface of the eye) in people treated for blepharospasm. People who receive XEOMIN to treat spasm of the eyelid may have reduced blinking that can cause a sore on their cornea or other problems of the cornea. Call your healthcare provider or get medical care right away if you have eye pain or irritation after treatment with XEOMIN.

XEOMIN may cause other serious side effects including allergic reactions. Symptoms of an allergic reaction to XEOMIN may include: itching, rash, redness, swelling, wheezing, trouble breathing, or dizziness or feeling faint. Tell your doctor or get medical help right away if you get wheezing or trouble breathing, or if you get dizzy or faint.

The most common side effects of XEOMIN in people with chronic sialorrhea include:

needing to have a tooth pulled (extracted)
dry mouth
- diarrhea
- high blood pressure

The most common side effects of XEOMIN in people with upper limb spasticity include:

seizure
- dry mouth

nasal congestion, sore throat and runny nose
- upper respiratory infection

The most common side effects of XEOMIN in people with cervical dystonia include:

difficulty swallowing
neck pain
muscle weakness
- pain at the injection site

muscle and bone pain

The most common side effects of XEOMIN in people with blepharospasm include:

drooping of the eyelid
dry eye
dry mouth
diarrhea
headache
- vision problems

shortness of breath
- nasal congestion, sore throat, and runny nose

respiratory infection

The most common side effect of XEOMIN in people with glabellar lines include:

headache

These are not all the possible side effects of XEOMIN.
Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

General information about the safe and effective use of XEOMIN.

Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide. You can ask your pharmacist or doctor for information about XEOMIN that is written for health professionals.

What are the ingredients in XEOMIN? Active ingredient: botulinum toxin type A

Inactive ingredients: human albumin and sucrose

Manufactured by: Merz Pharmaceuticals GmbH, Eckenheimer Landstrasse 100, Frankfurt Germany U.S. License Number 1830
Distributed by: Merz Pharmaceuticals, LLC, 6501 Six Forks Road, Raleigh, NC 27615 and Merz North America, Inc. 4133 Courtney Road, Suite 10, Franksville, WI 53126 Merz Pharmaceuticals, LLC, XEOMIN® is a registered trademark of Merz Pharma GmbH & Co KGaA.