SANTA ANA SKIN CARE CLINIC
683-B HARKLE RD
SANTA FE, N.M. 87505

FIRST NAME:_________________ LAST NAME:________________

DATE OF BIRTH:_____/_____/_____

MAILING ADDRESS:_______________________________________

CITY:______________ STATE:______________ ZIP:____________

WORK #:_________________ HOME #:________________________

SS#:_______________________

Email:_____________________

WHO REFERRED YOU TO OUR OFFICE?________________________

Thank you for choosing our office for all of your skin care needs. If at any time you have questions regarding your treatment please feel free to call the office. Please note that treatment fees are due at the time of services, and medical insurance does not cover treatments because they are considered a cosmetic luxury. Also note that the results of products and procedures are not guaranteed. Also all products and services offered through Santa Ana Skin Care Clinic are **non-refundable.**

________________________________ ________________________

SIGNATURE OF RESPONSIBLE PARTY DATE

MEDICAL HISTORY FOR COSMETIC INJECTIONS
BOTOX/COLLAGEN/RESTYLANE/RADIESSE/JUVIDERM

What is the reason for today's visit? ____

What medications are you allergic to? ____

Please list any other allergies you have. _______________________________________

What medications are you currently taking? _____________________________________

Please list any past surgeries you have had. _____________________________________

Please check all that apply:

Are you pregnant? Yes ____ No ____
Are you taking antibiotics? Yes ____ No ____
Are you taking any blood thinners? Yes ____ No ____
(*includes aspirin, ibuprofen, vitamin E, coumadin, etc.)*
Are you allergic to beef products? Yes ____ No ____
Do you smoke? Yes ____ No ____
Have you had Botox treatments before? Yes ____ No ____
If yes what was the date of your last treatment? ______________
Have you had collagen treatments before? Yes ____ No ____
If yes what was the date of your last treatment? ______________
Have you had restylane/radiesse/juviderm treatments before? Yes ____ No ____
If yes what was the date of your last treatment? ______________
Do you have muscular or nervous system disorders, such as Multiple Sclerosis or Myesthenia Gravis? Yes ____ No ____
Do you have a regular fitness program? Yes ____ No ____
Do you work out using weights? Yes ____ No ____
Do you get headaches or migranes? Yes ____ No ____
Do you have any neurological disorders? Yes ____ No ____
Please specify ______________________
Do you get seizures/blackouts? Yes ____ No ____
How often _________________________
Do you have strokes? Yes ____ No ____
Do you have thyroid disease? Yes ____ No ____
Do you have back/neck problems? Yes ____ No ____
Do you have high/low blood pressure? Yes ____ No ____
Do you have any heart conditions? Yes ____ No ____
Please specify ______________________

Do you have asthma/lung disease? Yes ____ No ____
Do you have hepatitis/liver disease? Yes ____ No ____
Do you have kidney/bladder disorders? Yes ____ No ____
Do you have diabetes? Yes ____ No ____
Do you have leg/ankle skin ulcers? Yes ____ No ____
Do you have stomach problems? Yes ____ No ____
Do you have arthritis? Yes ____ No ____
Do you have cancer? Yes ____ No ____
Please specify ____________________
Do you get skin rashes easily? Yes ____ No ____
Do you have Phlebitis? Yes ____ No ____
Do you have varicose or spider veins? Yes ____ No ____
Do have keloid scars? Yes ____ No ____

Do you have any other medical conditions that we should be aware of?
____

I certify that the information that I have provided above is accurate to the best of my knowledge. I understand that the treatment plan proposed for me and the results I can expect are partially based on the accuracy of the information I have provided. I understand that results of these procedures can not be guaranteed.

____ ____________________
Signature Date

INFORMED CONSENT FOR BOTOX, RESTYLANE, RADIESSE, JUVIDERM AND/OR COLLAGEN INJECTIONS

BOTOX

*Botulinum toxin Type A (brand name Botox) has been safely used for many years and is FDA approved for the treatment of facial muscle spasms resulting in crossed eyes and persistent eyelid twitching. Wrinkles of the skin above the nose, around the eyes, and over the brow can be produced by overactive muscles of facial expression. Injecting he medication into these tiny muscles can cause them to be temporarily weakened and halt their function, thereby improving the appearance of the wrinkles overlying them. The cosmetic use of Botox has been <u>FDA approved</u> only for reducing wrinkles of the glabella frown line, but has been safely and commonly used for the purpose of reducing other facial wrinkles for many thousands of patients since 1987. This procedure is known as cosmetic denervation.

*Wrinkles that can successfully be treated include the frown lines, crow's feet, and lines of expression caused by muscle activity. This treatment will not work to eliminate wrinkles due to loose or sagging skin.

*The treatment may cause a rash or a brief headache, although many patients have reported a dramatic decrease in tension headaches once the muscles become relaxed by the Botox. Very rarely the medication may spread to other nearby muscles and cause temporary ptosis (drooping) of an eyelid or unevenness of an eyebrow. These rare effects when they occur are not permanent and usually resolve completely within 2-4 weeks. In some patients Botox does not work as well as anticipated or last as long as expected. A touch-up re-treatment usually brings improved results.

*Results are normally noticed within 3-5 days, but it may take as long as 2 weeks before the full effect of the treatment is realized. The effects usually last for 3-6 month, at which time the procedure may be repeated, if desired. It may take more than one treatment session to a given area to achieve full results.

COLLAGEN

*CosmoDerm collagen implants are injected into the superficial papillary dermis for correction of soft tissue contour deficiencies, such as wrinkles and acne scars.

It may take up to 2 weeks for the full effect of the treatment to be realized. After the initial 2 weeks patients may come back for touch up treatments if desired. The effects of this treatment usually last for 3-4 months.

*CosmoDerm collagen implants contain lidocaine and must not be used in patients with known lidocaine hypersensitivity.

*Within the first 24 hours patients should avoid strenuous exercise, extensive sun or heat exposure and alcoholic beverages. Exposure to any of the above may cause temporary redness, swelling, and/or itching at injection sites.

*Borine collagen (Zyderm, Zyplast) require 2 negative skin tests 4 weeks apart prior to initial treatment.

RESTYLANE
*Restylane is indicated for mid-to-deep dermal implantation for the correction of moderate to severe facial wrinkles and folds, such as nasolabial folds.It may take up to 2 weeks for the full effect of the treatment to be realized. After the initial 2 weeks patients may come back for touch up treatments if desired. The effects of this treatment usually last for 6-9 months.
*Restylane contains trace amounts of gram positive bacterial proteins, and is contraindicated for patients with a history of allergies to such material.
*If laser treatment, chemical peeling or any other procedure based on active dermal response is considered after treatment with Restylane there is a possible risk of eliciting an inflammatory reaction at the implant site. This also applies if Restylane is administered before the skin has healed completely after such a procedure.

JUVEDERM
*Juvederm is a colorless hyaluronic acid gel that is injected into facial tissue to smooth wrinkles and folds, especially around the nose and mouth. Hyaluronic acid is a naturally occurring sugar found in the human body. The role of hyaluronic acid in the skin is to deliver nutrients, hydrate the skin by holding in water, and to act as a cushioning agent.
*Juvederm is injected into areas of facial tissue where moderate to server facial winkles and folds occur. Juvederm temporarily adds volume to the skin and may give the appearance of a smoother surface, and the results last for 6 month to 1 year. After the initial 2 weeks patients may come back for touch up treatments if desired.

RADIESSE
*Radiesse is an injectable filler that offers a non-surgical approach to shaping and contouring the face. This convenient treatment fills and corrects smile lines, Nasolabial Folds and wrinkles around the nose and mouth.
*Radiesse is made of unique calcium-based microspheres suspended in a natural gel that creates a scaffold through which the body's own collagen will start to grow, producing the desired long term effect. Results can last up to 24 months.

ARTEFILL
*Artefill is intended to be injected intradermally improve and soften smile lines, Nasolabial Folds and wrinkles around the nose and mouth.
*Artefill is a sterile gel composed of 30 to 50 micron microspheres of Polymethylmethacrylate in a slurry of bovine (cow) collagen with diluted lidocaine which is FDA apporoved for the permanent filling and to improve the appearance of the Nasolabial Folds.
*Artefill implants contain lidocaine and must not be used in patients with known lidocaine hypersensitivity.
*Artefill requires a negative skin test prior to the initial treatment.
*Artefill is a permanent filler, but may require 1-3 treatments for full results.

BOTOX/COLLAAGEN/RESTYLANE/JUVEDERM/RADIESSE/ARTEFILL

*The most common side effects associated with these treatments are bruising, swelling, redness, tenderness, induration and rarely acneform papules at the injection site.

*Patients who are using substances that reduce coagulation (i.e. aspirin, ibuprofen, non-steroidal anti-inflammatory drugs etc.) may, as with any injection, experience increased bruising or bleeding at injection site(s).

*These treatments are a contraindication for patients with severe allergies manifested by a history of anaphylaxis, or history or presence of multiple severe allergies.

*Use of these injections at specific sites in which an active inflammatory process (i.e. skin eruptions such as cysts, pimples, rashes, hives, etc.) or infection is present should be deferred until the inflammatory process has been controlled.

*These treatments should not be administered if you are pregnant, breast feeding, taking blood thinners, or have any neurological diseases, such as multiple sclerosis or myasthenia gravis. The effects of these injections may be greater if you are taking certain aminoglycoside antibiotics, such as gentamicin, tobramycin, spectinomycin, neomycin, kanamycin or amikacin. You must notify Dr. Lopez if you have any of these conditions or if you are taking any of these medications.

***I understand that these treatments, like the practice of medicine itself, are not an exact science. Therefore, no specific promises or guarantees of results can be made for any degree of improvement of my particular condition. There can be no refunds given for any treatment rendered.**

*I authorize the taking of pictures before and after treatment to be kept in my file. Photographs help to document my progress.

I certify that I have read and understand this document in its entirety. I certify that I do not have any medical conditions or take any medications that would have effect on this procedure as mentioned above. I voluntarily authorize Dr. Lopez, with or without an assistant, to administer Botox, Collagen, Restylane, Juvederm, Radiesse and Artefill injections.

__________________________________ __________________

Signature Date

PROCEDURE AGREEMENT FORM

_____ Initials Prior to receiving treatment, I have been candid in healing any condition that may have bearing on this procedure, such as: pregnancy, recent facial surgery, allergies, cold sores/fever blisters use of medication, etc.

_____ Initials I understand there may be some degree of discomfort, i.e.: stinging, pin pricking, hotness, tightness, etc.

_____ Initials I understand there are no guarantees as to the results of this treatment, due to Many variables, such as: age, condition of skin, smoking, etc.

_____ Initials I understand that I may or may not actually peel, that each case is individual.

_____ Initials I understand that the treatments performed here are considered cosmetic, and there can be no guarantees of insurance payment.

_____ Initials I understand that to achieve maximum results, I may need several treatments.

_____ Initials I understand that although complications are very rare, they may still occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the doctor or aesthetician who performed the treatment.

_____ Initials I agree to refrain from tanning booths while I am undergoing treatment, and during the 21 days following the end of treatment.

_____ Initials I understand that direct sun exposure is prohibited while I am undergoing treatment, and the use of sun block with a minimum SPF 15 is mandatory.

_____ Initials I have not had any other peel treatment of any kind within 14 days of this treatment. I understand I cannot have another treatment within 14 days of this treatment, whether the treatment is performed at this location or at any other location, unless directly expressed otherwise by the doctor or aesthetician.

_____ Initials I understand that if additional units of botox or additional restylane/collagen are needed I will be charged additional costs at regular price.

I hereby agree to all of the above statements and have answered true and to the best of my knowledge. I give consent to have treatment performed on me. I further agree to follow all post care instructions as I am directed.

______________________________________ ____________________

Patient Signature Date

FINANCIAL POLICY

Please read our financial policy and indicate your agreement by your signature. We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. All patients must complete the appropriate information forms before seeing a skin care provider.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. (Unless other arrangements are made directly with the office manager.)
We accept cash, check, Visa, American Express, Discover and Master card.

Private pay patients: Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan or paid by cash, check, or credit card at the time of services.

Insured patients: If you have insurance we will help you receive maximum benefits. We will give you properly completed "super bills" so that you can file your own insurance and be reimbursed to the extent of your coverage. We only file claims to insurance companies that we are participating providers for. Filing a claim is not a guarantee of payment. Many of our services are considered to be a cosmetic luxury and are therefore not covered by insurance. You are responsible for the full payment of any denied claims.

Insurance: This is a contract between you and your insurance company. In many cases we are not a party to this contract. We will inform you if we are a party to your contract, and we will handle your claims according to our agreement with your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance usual and customary charges, etc. other than to supply actual information as necessary. You are responsible for timely payment on your account.

Missed appointments: Unless canceled or rescheduled at least 24 hours in advance, our policy is to charge $50 for missed appointments. Please help us serve you better by keeping scheduled appointments.

Balance due terms: Your signature below indicates your agreement with our terms for any unpaid balance due. Unpaid balances due will begin accruing interest at the rate of 12% per annum, for balance due over 30 days. If it becomes necessary to employ an attorney or collection agency to collect an unpaid balance due, those fees will be added to the balance due. If you are unable to pay a balance due, please discuss payment arrangements with our office manager.

Please Note: All products and services offered through Santa Ana Skin Care Clinic are non-refundable.

Responsible Party Signature:________________________________ Date:__________

PRIVACY POLICY

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice summarizes how we handle your information, and provides further details of our privacy policies and procedures.

How we may use and disclose your information: We use health information about you for your treatment, to get paid for treatments, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for these reasons. Beyond those situations, we will ask for your written authorization before using of disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop further uses or disclosures.

Your rights: In most cases you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we will charge you a cost-based fee and these copies will be made within 30 days. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

Our legal duty: We are required by law to protect the privacy of your health information; provide this notice about our privacy policies; follow the privacy practices that are described in this notice; and seek your acknowledgement of receipt of this notice. We may change our privacy policies at any time. Before we make significant changes in our privacy policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time.

Privacy complaints: If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

If you have any questions or complaints, please contact:

Elena Winters
683 B Harkle Road
Santa Fe, NM 87505

(505) 954-4422 ext 1004

Responsible party signature:___________________________________ Date:__________

PROCEDURE CLAIM REVIEW FORM

Santa Ana Skin Care Clinic would like to make you aware that in the in the event that we should submit a claim to your insurance company for a procedure reviewed here at our clinic, your insurance provider always reserves the right to review and deny any claim they receive. We may be able to find out for you if the procedure does not require a pre-authorization, but these procedures are still subject to review and possible denial. The only time your insurance company is obligated to pay any amount is if they give you a confirmed pre-authorization number which we will keep in your chart making you not responsible for payment; unless the treatment amount is applied towards a deductible then you will still be held responsible for payment. Your signature below indicates you agree to abide by the policy in this form.

I ______________________________ have read and understand the Insurance Procedure Claim Review Form.