

Patient Information

Drops of Beauty Anti-Aging Medical Spa

Last Name: _____ First Name: _____ M.I. _____

Date of Birth: ____ / ____ / ____ Address: _____

City: _____ State: _____ Zip: _____ Phone Number: (____) _____

E-mail: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about our spa? (Please specify) _____

Assignment of Financial Responsibility

I agree that I am responsible for the charges in full for services rendered. I agree to pay all finance charges, billing charges and all collection fees that may be incurred to collect any balance that may be owed.

Cancellations and Refund Policies

TREATMENTS: All treatments, procedures and/or prepaid packages are non-refundable. Packages are non-transferable and must be used within one year from the date of purchase. Credit from prepaid treatments, procedures, and/or packages may be applied toward other forms of treatment(s) or product(s) only at management's discretion. Credit can be given to and used by purchaser only. **NO REFUNDS - EXCHANGES ONLY.**

PRODUCTS: Many of the products sold in our practice are considered "medical grade" products, and can only be purchased from, or sold by, a licensed professional. We do not accept returns on any product. A spa credit may be issued depending on the circumstance and is at management's discretion. Your signature on this document serves as your acceptance and understanding of our "no return" policy. A copy of this document will be kept in your chart and is available for your review at any time.

CANCELLATIONS: We understand that emergencies do arise; however, we request a 24-hour notice for rescheduling or canceling all appointments. Failure to do so may result in a charge on your account. **"NO SHOWS" WILL BE BILLED FOR THE SCHEDULED TREATMENT.**

APPOINTMENTS: To ensure your preferred Doctor or Technician is always available to you, we recommend scheduling your next appointment prior to leaving the Medical Spa. This is particularly important if you are having a series of treatments over a defined period of time. We will always try to schedule you with your requested provider, however, sometimes that provider will not be available and we will place you with our best recommendation.

ARRIVALS: Please arrive on time for your scheduled appointment. This ensures adequate timing for your well-deserved treatment and helps us in not intruding on the following clients' reserved time.

By signing below, I agree to the company's terms and conditions.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

PERSONAL PROFILE & MEDICAL HISTORY (1/2)

Name: _____ Date of Birth: _____

Females: Are you pregnant? ___Yes ___No Are you breastfeeding? ___Yes ___No

Your genetic background affects your skin and its response to many of our procedures. Please specify your ethnic origin:

____ African American ____ Asian ____ Caucasian ____ Hispanic
____ Mediterranean ____ Middle Eastern ____ Native American ____ Other _____

Complete the following items of medical history. Please, always inform us of any changes in your medical history and/ or medications.

Please list **all medications** including prescription and over the counter drugs, vitamins, herbs, **blood thinners, aspirin**, and/or supplements.

Allergies to medications?

Please check if any of these conditions apply to you

____ Acne	____ High Blood Pressure	____ Precocious Puberty
____ Bleeding Disorders	____ Hirsutism	____ Psoriasis
____ Burns/Skin Grafts	____ Hormone Replacement Rx	____ Rosacea
____ Claustrophobia	____ Cold Sores	____ Implants
____ Seizures	____ Diabetes	____ Kaposi's Sarcoma
____ Shingles	____ Eczema	____ Keloid Scars
____ Skin Cancer	____ Endocrine Disorders	____ Lupus Erythematosus
____ Tattoos	____ Epidermolysis Bullosa	____ Thyroid Disease
____ Gold Therapy	____ Polycystic Ovary Disease	____ Vitiligo
____ Heart Disease	____ Port- Wine Stain	____ Permanent Makeup
____ Herpes	____ Hepatitis	____ HIV/ AIDS

Have you suffered from any neurological illness in your past? If yes, please specify:

____ ALS ____ MS ____ Guillain Barre' ____ Myasthenia Gravis

Other: _____

Have you ever had surgery? If yes please specify:

Please describe any other pertinent medical information:

PERSONAL PROFILE & MEDICAL HISTORY (2/2)

If the answer to any of the following questions is yes, please provide details.

- | | |
|--|-------------------|
| 1. Have you used Accutane in the last 6 months? | Yes No |
| a. If yes, how recently? _____ | |
| 2. Are you currently using glycolic acid or Retin A? | Yes No |
| 3. What products are you currently using on your skin? Please describe: _____ | |
| _____ | |
| 4. Do you have any active skin diseases or infections in the area to be treated? | Yes No |
| 5. Are you allergic to latex, lidocaine, or any lotions? | Yes No |
| 6. Have you had any permanent cosmetic tattooing to the area to be treated? | Yes No |
| 7. Do you have any metal or other implants? Where? | Yes No |
| 8. Have you had any previous laser or other skin treatments on the area to be treated? | Yes No |
| 9. Are there any moles with hair in the area to be treated? | Yes No |
| 10. Do you have any history of skin breakouts? | Yes No |
| 11. Do you have any scarring as a result from breakouts/acne? | Yes No |
| 12. Have you been exposed to the sun within the last four to six weeks? | Yes No |
| a. If yes, state the approximate date of last exposure _____/_____/_____ | |
| 13. Do you use tanning beds. If yes, state the date of last use | _____/_____/_____ |
| 14. Do you burn easily in moderate sunlight? | Yes No |
| 15. Do you blush easily when nervous? | Yes No |
| 16. Do you frequently experience flakiness, tightness or dryness? | Yes No |
| 17. Do you use sunscreen on a regular basis? | Yes No |
| 18. Have you waxed, used depilatories, bleaches or other chemical processes? | Yes No |
| 19. How many glasses of water do you usually drink in a day? | _____ |
| 20. Do you smoke? | Yes No |
| 21. Do you wear contact lenses? | Yes No |
| 22. Do you exercise? | Yes No |
| 23. Have you had microdermabrasion? | Yes No |
| 24. Have you had any chemical peels? | Yes No |
| 25. Have you had laser resurfacing? | Yes No |
| 26. Do you have wrinkle concerns? | Yes No |
| 27. Do you have scarring concerns? | Yes No |
| 28. Do you have sun damage concerns? | Yes No |
| 29. Do you have pigmentation concerns? | Yes No |
| 30. Do you have broken capillary concerns? | Yes No |

What services are you most interested in? _____

Name of your Primary Care doctor: _____ Phone #: (_____) _____

I confirm that the answers to the questionnaire are true and correct.

Print Name: _____

Signature: _____ Date: _____
(Parent or Guardian if patient is under 18)

Drops of Beauty Medical Spa Office Policies

At Drops of Beauty Anti-Aging Medical Spa we strive to ensure the highest quality of care and comfort. Our policies have been designed to provide a truly relaxing and tranquil environment. Come join us to *Relax. Restore. Renew.*

Punctuality

Please arrive at least 15 minutes before your scheduled treatment for check-in and any possible clothing changes. If you happen to be late we offer two choices.

- You may shorten your treatment because of time constraints and other clients' schedules.
- You can reschedule your appointment with a \$25 cancellation fee to accommodate our professionals.

In case of prepaid vouchers your single treatment will be forfeited. If you would like to reinstate that treatment, a fee equal to the single treatment will apply.

Cancellation Policy

Drops of Beauty Medical Spa understands that you may have to cancel an appointment sometimes. However, we require that a 24-hour notice must be given. Failure to do so will result in a \$25.00 charge of your scheduled treatment to your credit card.

Payments

Our available payment options are credit and debit cards (including American Express), cash, Discover and gift certificates.

Gift Certificates

Gift Certificates are available at the reception desk or through the med spa coordinator at the time of your consultation. Gift Certificates are required at the time of service and must be redeemed within one year from the date of purchase.

Tipping and Gratuity

Gratuity is greatly appreciated. Gratuity is not included in your spa treatment certificates, prepaid vouchers or cosmetic procedures. Typical gratuity is 20% of full service price (usually \$20 minimum). Gratuity is appreciated for touchups and for complimentary services.

Children and Cell Phone Courtesy

Drops of Beauty Spa is a tranquil environment. To preserve the serenity, please do not bring children to your scheduled appointments and turn off all cell phones. Thank You.

Refunds

No refunds will be given on products, services, and gift certificates. This includes prepaid services including Botox/Dysport and fillers, all retail and all services.

Exchange of Series, Packages and Programs

When purchasing a series of treatments or bundled packages, a discounted rate is given at the time of purchase; payment must be made at the beginning of treatment. The series are non-refundable, and non-transferable. However, should you choose during your series to opt for a different service any remaining balance may be applied to a different treatment. When canceling a series, we deduct full price of used services.

Acknowledgement Signature

Date

Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All claims Must be Arbitrated: It is also understood that any dispute that does not related to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a backup for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's prorated share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute the right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to intrude evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgement for future agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should **Initial Here**_____. Effective at the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Print Name_____

Office Signature_____ Date_____

Consent for Dermal Filler and PRP Injections

I understand that I will be injected with one or multiple of the following fillers: Restylane, Restylane Silk, Restylane Lyft, Radiesse, Voluma, Juvederm, Volbella, Belotero hyaluronic acid dermal fillers, or PRP (Plasma).

Dermal fillers and PRP have been FDA approved for use in cosmetic treatments for moderate to severe wrinkles around the nose and mouth. I understand this treatment is temporary, and re-injection is necessary after about six months. It has been explained to me that other temporary and more permanent treatments are available.

The following complications may occur with the dermal filler injection procedure:

1. Risks: I understand there is a risk of bruising, redness, swelling, pain at the injection site, tenderness, itching, allergic reaction, and raised bumps of skin (nodules). These symptoms are usually mild and typically last a few days but can last up to a few months. In rare cases bruising can last several months and even be permanent.
2. Infection: Post treatment bacterial, viral and/or fungal infections can occur which in most cases are easily treatable but in rare cases a permanent scarring in the area can occur.
3. Effectiveness: Treatments can last anywhere from 4-6 months up to one year.
4. Treatments: I understand more than one injection may be needed to achieve a satisfactory result.
5. Allergic Reactions: In rare cases, there may be an allergic reaction to the injection.
6. There is a risk of scarring.
7. I will follow all aftercare instructions as it is crucial I do so for healing.
8. Drops of Beauty provides complimentary numbing prior to administering fillers, please advise your technician prior to procedure if you are allergic to any numbing agents (lidocaine, tetracaine, benzocaine or prilocaine). In addition, most dermal fillers contain the anesthetic lidocaine. If I have any allergies to lidocaine or any of the other numbing agents, I will inform my technician prior to the procedure.
9. As dermal fillers are not an exact science, there might be an uneven appearance of the face with some areas more affected by the fillers than others. In most cases this uneven appearance can be corrected by more injections in the same or nearby areas. However, in some cases this uneven appearance can persist for several weeks or months. On rare occasions, you may be severely bruised and/or severely swollen post treatment, we do not recommend any special events directly post filler procedures.

This list is not meant to be inclusive of all possible risks associated with dermal fillers as there are both known and unknown side effects associated with any medication or procedure. *Fillers should not be administered to a pregnant or nursing woman.*

The number of units injected is an *estimate* of the amount of fillers required to add volume to the skin and give the appearance of a smoother face. I understand there is no guarantee of results of any treatment and the regular charge applies to all subsequent treatments.

I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees, should this be required. By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. I hereby give consent to perform this and all subsequent dermal filler treatments with the above understood. I hereby release the doctor, the person injecting the filler and the facility from liability associated with this procedure.

Patient Signature: _____ Date: _____

Physician/Nurse Signature: _____ Date: _____

Pre-and Post-Filler Instructions

Pre-Filler Instructions

1. If you are prone to cold sores, please inform the front desk personnel (at the time of your appointment) or the nurse or doctor on duty.
2. Please come in for your dermal filler appointment with a clean face (i.e. no makeup).
3. No ASA (Aspirin), Ibuprofen, Vitamin E, alcohol, or any blood thinning agents within 48 hours of procedure.
4. No flying for 48 hours after procedure.
5. Do not go in for treatment if you have any infections.
4. Do not go in for treatment if you have severe allergies or you have a history of allergic reactions to gram-positive bacterial proteins.
5. All dermal fillers should be used with caution in patients on immunosuppressive therapy, or therapy used to decrease the body's immune response, as there may be an increased risk of infection.
6. The safety of dermal filler injections for use during pregnancy, in breastfeeding females, or in patients under 18 years has not been established.
7. We recommend waiting two weeks after all dental work (dental cleaning included) before getting fillers/PRP due to a higher risk of infection.

Post Filler Instructions

1. Immediately after your dermal filler procedure, you can expect redness, swelling, tenderness, or an itching sensation in the treated area. This is a normal result of the injection. The discomfort is temporary, and generally disappears in a few days.
2. Rest and drink a lot of water.
3. Use frozen peas or corn (loose) in a Ziploc bag. The goal is cold without pressure.
4. During the first 48 hours do not massage unless instructed to do so by the nurse or doctor.
5. It is acceptable to use Aspirin or Ibuprofen for discomfort.
6. Lay a cold banana peel, using the inner side of the peel, directly, on any bruises.
7. Eat raw pineapple to reduce bruising.
8. Use Homeopathic Arnica gel, topically, and Arnica Montana (30C), pellets, orally. Apply the gel as often as possible to affected areas. Take 4-5 pellets, under tongue, 4-6 times per day. Use same day before treatment and directly after treatment and for the weeks following treatment, until pain, swelling, bruising and discomfort have all subsided. Both the topical and oral work in conjunction to reduce healing time and to shorten the duration of bruises. You can get these from Sprouts or Whole Foods.
9. If you have had a lip enhancement procedure, avoid puckering your lips for the first 2 days after treatment, and no hard kissing.
10. Do not use makeup until the day after the procedure.
11. Try to sleep on your back, in a slightly reclined position (use pillows to prop yourself up, to avoid rolling over), for 1-2 weeks following treatment. Dermal Fillers can move if you sleep on your face or on your side.
12. After 7-14 days you can go back to your normal routine.
13. Please do not hesitate to call the office for any questions or concerns 602-688-7545.