Samantha HOLLAND RN

New Patient Intake/Consent Form

Name* _____ Age _____ DOB* _____

Address _____ City _____ Zip*_____

E-mail Address _____ Phone # _____

Emergency Contact name* _____ Phone #*_____

Occupation _____ Marital Status _____

Height _____ * Weight _____ *

Food/Medication allergies:*_____

Weekly alcohol intake*: 1-3 drinks/4-7 drinks/7-11 drinks/12+

Smoker: Past/Present/Never

List any prescription medications including dose: *

1.

2.

3.

List any herbal/vitamin supplements: *

1.

2.

3.

Samantha HOLLAND RN

Past medical history*

1. High Blood pressure? Y/ N

2. Heart disease? Y/ N

3. Thyroid disorder? Y/ N

4. Cancer? Y/N

5. Neurological disorder? Y/N

6. Kidney or Liver disease? Y/N

7. Glaucoma? Y/N

8. Diabetes? Y/N

9. Breathing problems? Y/ N

10. Abnormal EKG? Y/ N

11. Any implantable device including cheek or chin implant? Y/N

12. Other- please list

Women:

Are you pregnant? * Y/ N Breastfeeding? * Y/ N Last Menstrual Period date _____

Aesthetics Interest Questionnaire (please fill out if receiving any cosmetic treatment):

What most concerns you about your appearance (please circle all that apply): Wrinkles/Fine lines Laugh lines
Volume loss Dark spots Hooded eyelids Dry skin Jowls Lip volume
Smoker's lines Double chin/jawline definition Dark circles/tired eyes Aging hands

Are you interested in a B12 shot today? Y/N

Other concerns:

I consent to treatment as a new patient performed by Samantha Holland RN, BSN, MSN.

_____ _____

Patient Signature Date

Samantha Holland RN 3097 East Pecos Rd., Suite 104 Gilbert, Arizona 85295

Samantha HOLLAND RN

Botox/Xeomin/Dysport Informed Consent for Treatment

I, _____ hereby authorize treatment by Samantha Holland to perform Botox cosmetic, Xeomin or Dysport injections.

Possible side effects of these injections include but are not limited to:

- ➢ Swelling, rash, headache, local numbness, pain at the injection site, eyelid edema, flu like symptoms, bruising, respiratory problems /difficulty swallowing or allergic reaction.
- ➢ Weakness of adjacent muscles
- ➢ Temporary Drooping of the eye (Ptosis)

- I understand Botox is only FDA approved for crow's feet and glabellar lines (wrinkles between the eyebrows). 24 units are indicated for crows feet and 20 units for glabellar region. Xeomin and Dysport are FDA approved to treat glabellar lines. All other uses are considered off-label.
- I understand I should not use Dysport if I have a cow's milk protein allergy
- I understand it is not recommended to treat the forehead without co-treating the glabella (between the eyebrows). If I chose to do so it is at my own risk of a poor result as these muscles work together.
- I attest I have considered alternatives to this procedure and that this has been discussed with the medical provider
- I understand that botulinum toxins are not effective on everyone and there is no guarantee that results will be achieved.
- I understand there will be swelling at the injection site that usually goes down within an hour but can last longer.
- I understand botulinum toxins take 48 hours to begin working and may take up to 10 days for the full effects to be noticed.
- I understand botulinum toxins last between 2-6 months and that I will need repeated treatments to maintain their effectiveness.
- I understand the amount of botulinum toxins given is a recommended amount the injector has found to be therapeutic and what is recommended by the manufacturer of these medications.
- I understand that I may need an additional "touch up" appointment at which time there will be an additional cost.
- I agree not to lay down for four hours after injection and agree not to rub the injected area that day.
- I attest that I am not pregnant or nursing and have never had a severe reaction to Botox or have any existing neuromuscular conditions, as this treatment would be contraindicated for these reasons.
- I consent to taking of photographs during the procedure for educational purposes marketing and for observing clinical response.
  - ➢ Please initial here if choosing to opt out of marketing pictures _____
- I agree that all services provided are directly charged to me and that I am personally responsible for payment at time of treatment.

By signing this consent form, I am agreeing to be treated with botulinum toxins and have read the form in its entirety. I also release Samantha Holland and Fresh Approach Aesthetics from any responsibility associated with the side effects mentioned above.

_____ _____

Patient Signature Date

Samantha Holland RN 3097 East Pecos Rd., Suite 104 Gilbert, Arizona 85295

Samantha HOLLAND RN

Dermal Filler Informed Consent for Treatment

I, _____ hereby authorize treatment by Samantha Holland to perform dermal filler treatment.

- Juvederm Ultra,Ultra Plus, Restylane, Restylane L, Restylane Lyft, Restylane Refyne and Defyne are FDA approved to treat moderate to severe facial wrinkles such as nasolabial folds, Restylane is also FDA approved to treat lips. Juvederm Voluma and Restylane Lyft are FDA approved for volume loss in the cheek area. Juvederm Volbella and Restylane Silk are approved for lips and fine lines. Belotero is FDA approved for nasolabial folds. Radiesse is FDA approved for hands and for moderate to severe facial folds/wrinkles. All other uses are considered off- label.
- Possible side effects of dermal filler injections include but are not limited to:
  - Swelling, rash, bleeding at injection site, pain at the injection site, lumpiness, bruising (temporary and less commonly permanent), infection, or allergic reaction. An unintended but serious side effect with injectable fillers is injection into a blood vessel. Although this is a very small risk side effects can be serious and include blindness, stroke, or vision abnormalities.
- I attest I have considered alternatives to this procedure and that this has been discussed with the medical provider.
- I understand that everyone responds differently, and sometimes poor or inadequate results may be achieved. In most cases additional treatment can result in a good result.
- I understand there will be swelling in the area injection which can last days or even weeks.
- I understand that results are temporary and can last 3 months to 2 years depending on the filler chosen, and site injected.
- I understand the amount of filler given is a recommended amount the injector has found to be therapeutic and what is recommended by the manufacturer of the above dermal fillers. I understand that I may need an additional "touch up" appointment at which time there will be an additional cost.
- I understand that all of the listed fillers with the exception of Radiesse can be reversed. If I decide I want the product reversed there will be an additional fee.
- I consent to taking of photographs during the procedure for educational purposes, marketing and for observing clinical response.
  - Please initial here if choosing to opt out of marketing pictures _____
- I agree not to exercise for 24 hours and to avoid excessive heat. I also agree not to massage the product unless directly instructed to do so.
- I attest that I am not pregnant or nursing and have never had a severe reaction to dermal filler or bacterial proteins, as this treatment would be contraindicated for these reasons.
- I agree that all services provided are directly charged to me and that I am personally responsible for payment at time of treatment.

By signing this consent form, I am agreeing to be treated with dermal filler and have read the form in its entirety. I also release Samantha Holland and Fresh Approach Aesthetics from any responsibility associated with the side effects mentioned above.

_____ _____

Patient Signature Date

Samantha Holland RN 3097 East Pecos Rd., Suite 104 Gilbert, Arizona 85295

HIPAA Consent and Financial Policy

Samantha Holland RN and its employees are required by law to protect your health information. We have the right to change this notice, and if we do so we will notify you in writing. If we bill your insurance for any visits than we have an obligation to share information with your insurance company and our billing company. We may disclose information to attorneys, accountants, or credit card processors for legal purposes and general healthcare operations. We may also use your information without your consent for the following reasons: Emergency situations when we are unable to obtain your consent, when required by law, product recalls, victim of abuse/neglect/domestic violence, for public health activities (such as required reportable diseases), lawsuits and worker's compensation. You have the right to decide how Personal health information (PHI) is communicated, make amendments to your PHI, and obtain copies of your PHI. You have a right to the list of any disclosures we have made. If you feel we have violated your privacy rights you may contact the US Department of HHS government center. Any disclosure of your personal health information would require your prior written consent; this includes obtaining copies for yourself. PHI copy requests may take up to 10 days to receive. We will not disclose your PHI to any other healthcare provider without your written consent. In some cases it may be necessary for us to collaborate with your healthcare provider prior to initiation of a health program, in that case you will be notified of this and can chose to move forward or not.

Patient Signature _____ Date _____

Thank you for choosing Samantha Holland RN. We are committed to providing you with quality and affordable health care. We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

Patient payment: All balances/total due are to be paid at the time of service.

Missed appointments: Our policy is to charge $50 for missed appointments not canceled within 48 hours of the scheduled appointment. Rescheduling the appointment does not mean this fee will be waived as we often are not able to book that time slot with such short notice. These charges will be your responsibility. Please help us serve you better by keeping your regularly scheduled appointment.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines. I consent to treatment as a new patient performed by Samantha Holland RN, BSN, MSN.

Patient Signature _____ Date _____

Print Patient Name _____ Date of Birth _____

Samantha Holland RN 3097 East Pecos Rd., Suite 104 Gilbert, Arizona 85295