Capital Medical Group --CAPITAL AESTHETICS

Personal Profile and Health History

Name:____Home Phone:____________________________

Address:____Work Phone:____________________________

City/State/Zip: ____

Date of Birth: __________________________________Age:_________Gender: M____F_____

Occupation: __________________________________ Email address:_______________________________

How did you hear about us? ____

What cosmetic/aesthetic procedures are you interested in?

____

____

Please share any questions, concerns or comments:____

Females: Are you pregnant? ❑ Yes ❑ No   Are you breastfeeding? ❑ Yes ❑ No
Are you planning pregnancy during the course of your treatment? ❑ Yes ❑ No

Your genetic background affects your skin and its response to the laser. Please specify your ethnic origin:
❑ African American ❑ Asian ❑ Caucasian ❑ Hispanic ❑ Mediterranean
❑ Middle Eastern ❑Native American ❑ Other _______________________________

Please complete the following items of medical history. Please, always inform us of any change in your medical history and/or medications. Please list **all** medications including prescription and over the counter drugs, vitamins, herbs, supplements.

____

____

Are you allergic to any medications? ❑ Yes ❑ No Please list medications and reactions.____________

☐Acne	☐ High Blood Pressure	☐ Permanent Makeup
☐Bleeding Disorders	☐ Hirsutism	☐ Precocious Puberty
☐Burns/Skin Grafts	☐ Hormone Replacement Rx	☐ Psoriasis
☐Cold Sores/Fever Blisters	☐ Implants	☐ Seizures
☐Diabetes	☐ Kaposi's Sarcoma	☐ Shingles
☐Endocrine Disorders	☐ Keloid Scars	☐ Skin Cancer
☐Excessive Bleeding	☐ Liver Disease	☐ Tattoos
☐Gold Therapy	☐ Lupus Erythematosus	☐ Thyroid Disease
☐Heart Disease	☐ Mental Disease	☐ Vitiligo
☐Herpes	☐ Neuromuscular Disease	☐ Other _____________

Personal Profile and Health History

☐ Have you had surgery in the area to be treated? If "Yes", please explain
____

____

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

Are you currently being treated for any medical conditions? Yes No
Explain:____

Do you smoke? If so # per day?_________________ _________________ Yes No
Do you drink alcohol? Amount per day? ___________________________ Yes No
Have you used Accutane in the last 6 months? How recently? _________ Yes No

Do you have any active skin diseases or infection in the area to be treated? Yes No
Do you have any skin allergies? Yes No
Are you allergic to latex, lidocaine, or any lotions? Please circle any that apply Yes No
Are you currently using glycolic acid or Retin A? Please circle any that apply. Yes No
Have you had a chemical peel or facial within the last week? Yes No
What products are you currently using on your skin?
Describe: ____
Have you had any permanent cosmetic tattooing to the area to be treated? Yes No
Do you have any metal or other implants? Where? __________________ Yes No
Have you had any previous laser treatment or other skin treatment to the area
to be treated? Describe: ____________________________________ Yes No
Are there any moles with hair in the area to be treated? Yes No
Are you currently using or have used within the last six weeks a tanning bed or
tanning cream? If yes, date of last use __________________________ Yes No
Have you been exposed to the sun within the last four to six weeks? Yes No
If yes, approximate date of last exposure ________________________

Name of your family doctor: ____________________________ Phone No. ______________

I confirm that the answers to the questionnaire are true and correct. I also confirm that the consultant has clarified any questions I did not understand.

Signature of Client: ____Date:________________________

Signature of Dr./ARNP/PA _____________________________________ Date:________________________

Capital Medical Group --- Capital Aesthetics

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FINANCIAL POLICY

Payment for Aesthetic Services is required at the time of service. These services are considered cosmetic in nature and therefore are not billable to health insurance plans.

Cancellations must be made 24 hours in advance of your appointment time. No shows or cancellations with less than 24 hours notice may result in a $25 charge.

Please expect to pay in full for the service on the day it is performed.

We accept

CASH

CHECKS

Most Major Credit Cards: Visa, Master Card, American Express, Discover

CareCredit: no interest and extended payment plans subject to credit approval.

I acknowledge that I have read the financial policy above and understand that I am responsible for payment for my services at the time of service.

____ Date:____________

Informed Consent
Removal of Pigmented Lesions
and/or Spider Veins

Name: ____Date: _____________________________

I authorize ___________________________, to perform the procedure. The laser system may dramatically reduce darkly pigmented sunspots and spider veins. More than one laser session may be necessary to achieve desired results. However, other treatments, including skin care products, are often needed to blend color, reduce sun damage, and give the best results.

We are unable to treat clients that are on ACCUTANE and PHOTOSENSITIZING medications. Clients using ANTICOAGULANTS should be noted.

The following problems may occur with treatment:

1. I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied.

2. I understand that although uncommon, complications can occur. These complications include local infection, pigmentation changes, scarring, redness, swelling, tenderness, and temporary worsening of the appearance of my veins. I understand that many of these complications are temporary, however I acknowledge that although uncommon the pigmentation changes and scarring can be permanent.

3. I understand there are no guarantees implied as to the results of this treatment, due to many variables, such as age, skin type, skin condition, sun damage, smoking, alcohol, environmental exposures, etc.

4. I acknowledge that I have been candid in revealing any condition which might have an effect on this treatment, such as: pregnancy, medications, previous or recent skin surgery or treatment, skin cancer, cold sores/fever blisters, allergies, use of Retin-A, Accutane, Differin or hormones.

5. I understand that direct sun exposure is prohibited while I am undergoing treatment. The use of sunblock protection with a minimum SPF of 30 is recommended. I agree to refrain from skin tanning in tanning booths while I am undergoing treatment, and during the 14 days following my last treatment.

6. If I am prone to Herpetic outbreaks around the mouth, I have been advised to see my physician for a prescription for Acyclovir or Zovirax.

7. I agree to refrain from any skin care treatment, cosmetic or medical, 14 days preceding and 14 days following any treatment, including filler injections and BOTOX® Cosmetic treatments.

8. I understand that I will not be allowed to have treatments during any pregnancy. My unused treatment fees will be refunded or the unused portion will be placed on hold.

9. Compliance with the aftercare guidelines is crucial for healing, prevention of scaring, hyper-pigmentation and hypo-pigmentation.

I have read and understand this agreement and all my questions have been addressed and answered to my satisfaction. I consent to the terms of this agreement.

Client Name: ____

Signature: ____

Witness: ____

Date: ____

I, the undersigned medical professional, hereby certify that I have reviewed the foregoing treatment consent with the named patient (including the risks of and alternatives to treatment) on or prior to the first date of treatment and have given the patient the opportunity to ask questions regarding his or her treatment, including the opportunity to communicate with a physician.

Medical Professional: ____

Date: ____

<u>Pre</u> Treatment Instructions for Treatment of <u>Pigmented Lesions</u>

- ☑ Discontinue sun tanning and the use of tanning beds and self-tanning creams four weeks before and throughout the treatment course. This will reduce the chance of skin color changes, and development of new lesions.

- ☑ Always use a SPF-30 or greater sunscreen on all exposed treatment areas and re-apply as necessary. Wear protective, light-occluding hats and clothing.

- ☑ Discontinue use of exfoliating creams such as Retin-A and other skin exfoliating products two weeks prior to and during the entire treatment course.

- ☑ If you have a history of herpes outbreaks in the area of treatment, you should consult either your Primary Care Provider or our medical staff for medical evaluation and possible prophylaxis prior to treatment.

- ☑ An accurate diagnosis by a skin care physician of brown spots prior to treatment is necessary before treatment of lesions.

- ☑ Be aware there is the possibility of coincidental hair loss when treating pigmented lesions in hair bearing areas.

- ☑ Topical anesthetics are generally not needed for this procedure.

- ☑ Please do not wear make-up on the areas to be treated, or at least wash it off prior to being seen by the laser specialist.

- ☑ If excessive hair is present over the lesions to be treated, it should be shaved/removed at least 24-48 hours prior to treatment so as not to absorb laser light.

- ☑ Some people find it helpful to take two or three plain Tylenol or two or three OTC Advil (ibuprofen) 2 hours before coming in for treatment. Some women who find that they are less sensitive after their menses prefer to schedule their treatment sessions to avoid the premenstrual and menstrual time. You will be less sensitive if you are well rested, well fed, and not thirsty when you have your treatment. You should pamper yourself on laser days!

- ☑ During the treatment, remember that: "We want to be doing this FOR you, not doing it TO you." Unexpected discomfort is Nature's way of telling us something is wrong, so please tell us and we will go slower, apply more cooling, or adjust the power of the laser for you.

Post Treatment Instructions for Treatment of Pigmented Lesions

- ☑ A mild sunburn-like sensation is expected. This usually last 2-24 hours but can persist up to 72 hours. Mild swelling and/or redness may accompany this, which usually resolves in 2-3 days. In some cases, prolonged redness or blistering may occur. A non- steroidal anti-inflammatory (such as ibuprofen or naproxen) or acetaminophen will help reduce discomfort. Take according to manufacturer's directions.

- ☑ Apply cold gel packs or cool wet clothes to treatment areas for 15 minutes every two to four hours until symptoms subside.

- ☑ Bathe or shower as usual. Treated areas may be temperature sensitive. Cool showers or baths will offer relief.

- ☑ Avoid aggressive scrubbing and use of exfoliates, scrub brushes and loofa sponges until the treatment area has returned to its pre-treatment condition.

- ☑ Follow-up treatments are usually performed at 4-6 week intervals.

- ☑ Blistering or scaling is very uncommon, but usually resolves over a few days or a week with a bit of Polypore cream several times a day. If blistering occurs, apply topical antibiotic to the area two times a day until healed.

- ☑ Use SPF-30 sunscreen on treated areas if sun exposure is unavoidable. Sun avoidance will decrease the likelihood of skin color changes.

- ☑ Avoid shaving, waxing, swimming, hot tub/Jacuzzi, and do not apply any cosmetics to the treated area while irritated. Avoid excessive exercise until the redness resolves.

Skin Type Form

Skin type is often categorized according to the Fitzpatrick skin type scale, which ranges from very fair (skin type I) to very dark (skin type VI). The three main factors that influence skin type and the treatment program:

Genetic disposition ***Reaction to sun exposure*** ***Tanning habits***

Skin type is determined genetically and is one of the many aspects of your overall appearance, which also includes color of eyes, hair, etc. The way your skin reacts to sun exposure is another important factor in correctly assessing your skin type. Recent tanning (sun bathing, artificial tanning or tanning creams) has a major impact on the evaluation of your skin color. Please help us determine your skin type and treat you the right way. Please take a few minutes to fill-out this questionnaire, ***circling the most appropriate response***.

Name___________________________________

Genetic Disposition

Score	*0*	*1*	*2*	*3*	*4*
What is the color of your eyes?	Light blue, Gray, Green	Blue, Gray or Green	Hazel/ Brown	Dark Brown	Brownish Black
What is the natural color of your hair?	Sandy Red	Blond	Chestnut/ Dark Blond	Dark Brown	Black
What is the color of your skin (non-exposed areas)?	Reddish	Very pale	Pale Beige tint	Light Brown	Dark Brown
Do you have freckles on **unexposed** areas?	Many	Several	Few	Incidental	None

Score for Genetic Disposition [ ]

Reaction to Sun Exposure

Score	*0*	*1*	*2*	*3*	*4*
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rare burns	Never burns
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very Sensitive	Sensitive	Normal	Very resistant	Never had a problem

Score for Reaction to Sun Exposure [ ]

Tanning Habits

Score	*0*	*1*	*2*	*3*	*4*
When did you last expose your body to sun (or artificial sunlamp/tanning cream)?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago
When in the sun, do you expose the area to be treated?	Never	Hardly ever	Sometimes	Often	Always

Score for Tanning Habits [ ]

What color is the hair in the area to be treated?__________________________

		Skin Type Score	Skin Type	Skin Color
	🡄 Genetic Disposition Score	0-7	I	Very fair, "transparent"
	🡄Reaction to Sun Exposure Score	8-16	II	Fair
	🡄Tanning Habits Score	17-25	III	Fair to light olive
	🡄Total Score	26-30	IV	Olive to brown
	🡄Skin Type	Over 30	V-VI	Dark Brown - Black

USE OF PHOTOGRAPHS

EXPLANATION:

This consent form authorizes this clinic and individual members of the clinic's staff to use photographs of pre-treatment, post-treatment, and treatment in progress for the purposes of teaching, research and as illustrations of typical expected results. Under no circumstances will any publication or material bear any name or personal identifier. Your refusal to consent to use these photographs for purposes other than medical record documentation will in no way influence your treatment.

CONSENT:
I understand the photographs taken of me shall be used for documentation in my medical record and if in the judgment of the medical health care professional, medical research, education or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in conjunction with each other. In professional journals or medical books, or used for any other purpose which my health care professional may deem proper in the interest of medical education, knowledge or research.

I waive the rights that I may have to any claims for payment or royalties in connection with any exhibition, televising or publication of these photographs.

I release and hold harmless the clinic, staff and consultants from any liability in connection with the use of such materials.

I understand that the foregoing consent is subject to the limitation: Under No circumstances will any such publication, film photograph, video or material exhibited contain my name unless voluntarily disclosed by me.

Signature of Patient	Signature of Witness
Printed Name of Patient	Printed Name of Witness
Date	Date