SkínMedix®

PATIENT INFORMATION

FIRST NAME | LAST NAME | MIDDLE

DATE OF BIRTH | AGE

STREET ADDRESS | APT# | CITY | STATE | ZIP

CELL PHONE | ALT PHONE

SPOUSE OR EMERGENCY CONTACT | EMERGENCY CONTACT PHONE

EMAIL

FRIEND REFERRAL: _____ (They will received a $20 Credit!)

PAYMENT POLICY: WE ACCEPT CASH, CREDIT CARDS, DEBIT CARDS AND APPLE PAY. WE DO NOT ACCEPT CHECKS.

_____
INTIAL

CONFIRMATION & APPOINTMENT REMINDER POLICY: PLEASE SELECT YOUR NOTIFICATION PREFERENCES. *NOTE: IF WE DO NOT RECEIVE A CONFIRMATION RESPONSE THE DAY BEFORE YOUR SCHEDULED APPOINTMENT, YOUR APPOINTMENT MAY BE CANCELED!*

❏ TEXT REMINDER ❏ EMAIL REMINDER ❏ PHONE CALL

_____
INTIAL

CANCELLATION POLICY: TO KEEP OUR PRICES FAIR AND AFFORDABLE, WE REQUIRE 24-HOUR NOTICE IF YOU NEED TO CANCEL YOUR APPOINTMENT. SAME DAY CANCELLATIONS, AND NO CALL/NO SHOWS, RESULT IN US NOT HAVING A REASONABLE OPPORTUNITY TO FILL THAT TIME SLOT AND THIS INCREASES OUR COSTS. WE DO UNDERSTAND THAT LIFE HAPPENS, AND THAT LAST-MINUTE CHANGES & EMERGENCIES MAY OCCUR. TO ACCOMMODATE THESE SITUATIONS, OUR POLICY IS TO WAIVE ONE CANCELLATION FEE EVERY 6 MONTHS. IF YOU MISS A SECOND APPOINTMENT FOR ANY REASON, YOU WILL BE CHARGED $25 PER 15-MIN OF RESERVED APPOINTMENT TIME.

_____
INTIAL

REFUND POLICY: MEDICAL AESTHETICS IS NOT AN EXACT SCIENCE AND MANAGING EXPECTATIONS AND OUTCOMES THROUGH EDUCATING OUR PATIENTS ABOUT THE WIDELY KNOWN RISKS, COMPLICATIONS AND UNDESIRED OUTCOMES THAT CAN ARISE POST TREATMENT IS OUR FOCUS. ONCE A CONSENT IS SIGNED TO PROCEED WITH TREATMENT, NO REFUND WILL BE GIVEN AS THE SERVICE HAS BEEN RENDERED.

SIGNATURE | DATE

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GOOD FAITH EXAM

Do you have any known allergies? *(check all that apply)*

❑ Latex ❑ Sulfa ❑ Caine based drugs (i.e. Lidocaine, Tetracaine, etc.) ❑ **No known allergies**

❑ _____

Do you or a family member have or have had any of the following? *(check all that apply)*

❑ Asthma	❑ Eczema	❑ Amyotrophic Lateral Sclerosis	
❑ Facial Nerve Palsy	❑ Hay Fever	❑ Lambert-Eaton Syndrome	
❑ Motor Neurophathy	❑ Myasthenia Gravis	❑ Sinus Problems	❑ Thyroid Disease
❑ Active Skin Disease	❑ Anemia	❑ Bleeding Disorder	❑ Blood Pressure Problems
❑ Bowel Disease	❑ Cardiac Disease	❑ Connective Tissue	❑ Cold sore/Herpes/Blisters
❑ Deep Dermal Scarring	❑ Diabetes	❑ Heart Disease	❑ Hepatitis A B or C
❑ HIV/AIDS	❑ Keloid Scars	❑ Liver Disease	❑ Lupus
❑ Metal Implants	❑ Seizures	❑ Skin Cancer	❑ Stomach Ulcers
❑ Hypersensitivity to Botulinum A toxin products		❑ Other_____	
❑ Infection at the proposed injection site(s)		❑ **None known**	

Do you take or have recently been on these medications? *(check all that apply)*

❑ Accutane	❑ Aminoglycosides	❑ Antibiotics	❑ Anti-Platelet Agents
❑ Anticholinesterases	❑ Curare (non depolarizing blockers)		❑ Lincosamides
❑ Magnesium Sulfate	❑ Photosensitizing Medications	❑ Taking Steroids	❑ Polymyxins
❑ Retin-A/Bleach Cream	❑ Succinylcholine Chloride	❑ Quinidin	❑ Warfarin

Other medications _____

Do you drink alcoholic beverages? ❑ NO ❑ YES If yes, how many drinks a day?_____

Do you smoke? ❑ NO ❑ YES If yes, how much? _____

Are you currently lactating or are pregnant? ❑ NO ❑ YES

Are you frequently exposed to sunlight, even if you wear sunscreen? ❑ NO ❑ YES

What treatments/medications are you interested in? *(check all that apply)*

❑ Botox/Dysport	❑ Chemical Peel	❑ Dermal Filler	❑ Laser Skin Resurfacing
❑ RF Microneedling	❑ Bleaching Cream	❑ IPL	❑ Laser Hair Removal
❑ Dermaplaning	❑ Latisse	❑ Microdermabrasion	❑ Hollywood Laser Peel
❑ Skin Tightening	❑ Body Contouring	❑ Clear + Brilliant	❑ PRP (Platelet Rich Plasma)
❑ BHRT	❑ Facial	❑ Microneedling	❑ Spider Veins/Leg Veins
❑ Thread Lift	❑ Sculptra	❑ Hair Loss	❑ Facial Plastic Surgery
❑ Tattoo Removal	❑ Kybella	❑ Aqua Gold	❑ Rhinoplasty

Printed Name _____

Signature _____ Date _____

NP Signature _____ Date _____

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GENERAL CONSENT FOR TREATMENT

Patient Printed Name _____ **Date of Birth** _____

The focus at SkinMedix is educating patients about the treatments we offer, explaining the known risks, and managing realistic treatment expectations and outcomes. It is important that patients ask questions or voice concerns prior to receiving any treatment. Each patient is required to read and acknowledge the following information for all treatments performed at SkinMedix:

_____ INTIAL I understand that the practice of Aesthetic Medicine is not an exact science and I accept that no guarantees can be made about the results of any treatment and that Individual results will vary from person to person. Furthermore, I understand and that a series of treatments may be required to see results and that a small percentage of people may not respond at all to certain treatments.

_____ INTIAL I acknowledge that the risks and side-effects of aesthetic procedures has been explained to me. I accept that pain, allergic reactions, bruising, swelling, redness, tenderness, superficial wounds, crusting, flaking, dryness, pain, stinging, itching, nerve pain, muscle weakness, temporary changes in skin color and texture are normal and temporary side effects of most aesthetic procedures and that these side-effects usually resolve on their own over time.

_____ INTIAL I understand that the following medications and conditions can adversely affect treatment outcomes and that it is my responsibility to make my provider aware if I am taking any of the following medications and/or have any of the following conditions before my scheduled treatment:

• Pregnancy	• Nursing	• Recent surgery	• Allergies	• Active Electrical Implant
• RetinA	• Accutane	• Differin	• Antibiotics	• Impaired Immune System
• Blood Thinners	• Aspirin	• Aleve	• Motrin	• High Dose Vitamin E
• Celebrex	• Ginko Biloba	• St John's Wort	• Epstein Barr	• Muscle Weakness
• Cancer	• Heart Disease	• Pacemaker	• Tazorac	• Internal Defibrillator
• Cold Sores	• Metal Plates	• Recent Sun Exposure		• Uncontrolled Diabetes

_____ INTIAL To insure the best possible results, I agree to follow my Providers recommended treatment schedule, to follow the post-procedure instructions (i.e., appropriate wound care, sun avoidance, etc.) and to notify the office in a timely manner of any post procedure concerns or complications.

_____ INTIAL I understand that once a treatment has been provided, NO REFUND will be given as the service has been rendered.

My signature certifies that I clearly understand and accept the contents of this consent. A copy of this consent will be held on file at SkinMedix and will updated periodically.

Patient Signature _____ **Date** _____