Facial Aesthetics By Andrea

PATIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name_____ Today's date_____

Date of Birth_____Age_____Occupation_____

Home Address_____

City_____ State _____Zip Code_____

Cell phone (_____) _____Work phone (____) _____
home phone (____) _____

Email: _____

How would you prefer to be contacted? _____

Emergency contact name and phone_____

How were you referred to us? _____
(We give the person that referred you a $50 credit)

Do you regularly sun bathe or use tanning salons?_____How often?_____

Have you had previous treatment with BOTOX®? ❑Yes ❑No

Have you had previous treatment with dermal filler? ❑Yes ❑No

What areas were treated and were you happy with your results? _____

_____

MEDICAL HISTORY

Are you currently under the care of a physician? ❑Yes ❑No

If yes, for what:_____

Do you have any of the following medical conditions? (Please check all that apply)

❑Cancer ❑Diabetes ❑High blood pressure ❑Herpes ❑Arthritis

❑Frequent cold sores ❑HIV/AIDS ❑Keloid scarring ❑Skin disease/Skin lesions

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❑Seizure disorder ❑Hepatitis ❑Hormone imbalance ❑Thyroid imbalance
❑Blood clotting abnormalities ❑Any active infection

Do you have a history of Neuromuscular Disorders? (Please check all that apply)
❑Amyotrophic Lateral Sclerosis (LAS) ❑Multiple Sclerosis ❑Muscular Dystrophy ❑Myasthenia Gravis ❑Spinal Muscular Atrophy ❑Bell's Palsy

Do you have any other health problems or medical conditions? Please list: _____

_____

Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced) ❑Food ❑Animal Protein ❑Albumin (egg) products ❑Aspirin ❑Lidocaine ❑Hydrocortisone ❑Hydroquinone or skin bleaching agents ❑Others:_____

_____

_____

MEDICATIONS

What oral prescription medications are you presently taking? ❑Birth control pills ❑Hormones ❑Others (It is required that you list all of them): _____

_____

What antibiotics do you use to treat infections?_____

_____

Are you currently taking any antibiotics? If yes, please list: _____

Do you take any medications for heart conditions? _____

_____

Are you taking Anticoagulants or medications to thin your blood (i.e. Plavix, Coumadin, Aspirin, Baby Aspirin) _____

Are you on any mood altering or anti-depression medication?_____

What topical medications or creams are you currently using? ❑RetinA , ❑Others (Please list):

_____

What herbal supplements do you use regularly?_____

Do you smoke? ❑Yes ❑No If yes, how many packs per day/week _____

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Do you drink alcohol? ❑Yes ❑No If yes, how much and how often? _____

For our female clients:

Are you pregnant or trying to become pregnant? ❑Yes ❑No Are you breastfeeding? ❑Yes ❑No

Are you using contraception? ❑Yes ❑No

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the Medical Director, Andrea Popp-Connolly RN & Claire Flint APRN of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures. I agree not to hold Facial Aesthetics at Bedford Dental Care, Andrea Popp-Connolly RN, Claire Flint APRN and the current medical director of Facial Aesthetics at Bedford Dental Care and/or any other employee under Facial Aesthetics at Bedford Dental Care responsible for any adverse medical condition that may result from not disclosing any pertinent medical information.

Signature of Patient _____ Date:_____

Signature of Medical Director _____

Injector Signature: _____

Allergan MEDICAL INSTITUTE
Advancing Excellence in **Facial Aesthetics**

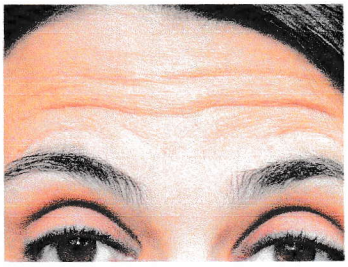
Patient Interest Questionnaire

Name: Age: Date: / /

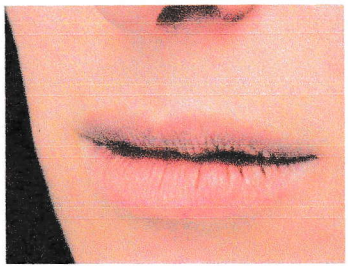
Please indicate any areas of concern for you

Check all that apply.

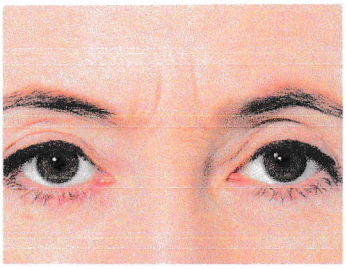
- ☐ Forehead lines



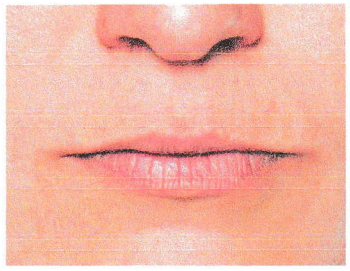
- ☐ Lip appearance and texture



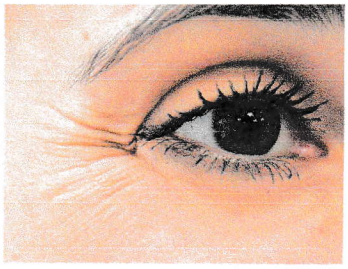
- ☐ Frown lines



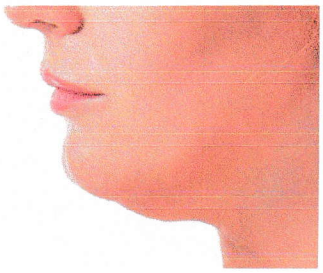
- ☐ Thin lips



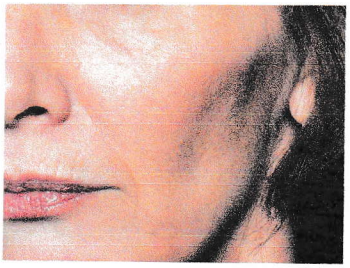
- ☐ Crow's feet lines



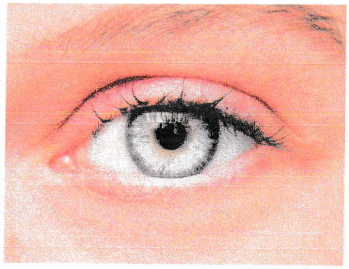
- ☐ Double chin



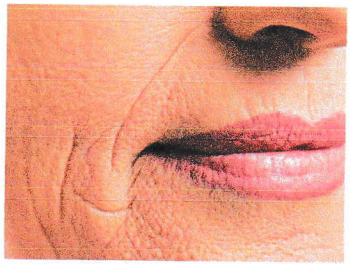
- ☐ Flattened cheeks/ sunken cheeks



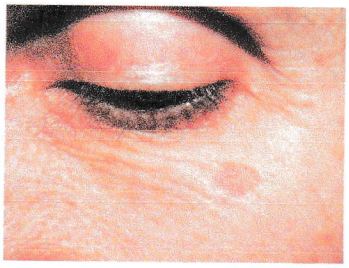
- ☐ Thinning or inadequate lashes



- ☐ Lines and wrinkles around the nose and mouth



- ☐ Skin appearance and texture



Be sure to bring this to your aesthetic specialist for your assessment.

Aesthetic specialist: See the next page to create the patient's treatment recommendations.

Botulinum Toxin (Botox®/Dysport®) Treatment Consent Form

Botox®/Dysport® therapy for wrinkles is an injection treatment designed to reduce facial expression lines. Botox®/Dysport® is the trade name for botulinum purified neurotoxin complex. Botox®/Dysport® is approved for the treatment of disorders of the muscles of the eye, certain types of headaches and other medical conditions. As well, it is approved for frown lines between and just above the eyebrows. The use of Botox®/Dysport® for other wrinkles (crow's feet, forehead lines) is, at this time, considered "off label". Nonetheless, Botox®/Dysport® therapy for all such wrinkles is a commonly performed cosmetic procedure throughout the world.
When Botox®/Dysport® therapy for wrinkles is performed, tiny amounts of the drug are injected into the facial muscles thus weakening them. This reduces the associated lines and wrinkles. Botox®/Dysport® therapy for wrinkles works best for "dynamic" lines and wrinkles which are the result of constant pulling on the skin by underlying facial muscles. Botox®/Dysport® therapy is less effective for fine textural changes on the skin surface (due to age-induced changes) and for those lines present at rest. The social signal read from a furrowed brow is one of negativism, frustration and anger. Lines adjacent to the eyes can make one appear tired and washed out.

Botox®/Dysport® therapy is temporary; meaning it will have to be repeated on a regular basis to remain effective. Nonetheless, you may stop and restart treatments at any time without negative effect. How long each treatment lasts will depend on many individual factors including the degree of sun damage present, the depth of the lines, the size of the muscles, the amount and strength of Botox®/Dysport® used, the frequency of re-treatment and the speed of neuro-muscular repair. An average response is 3-6 months of diminished muscle contraction. Individual responses may be longer or shorter depending on the above factors.

After Botox®/Dysport® is placed into the targeted muscles, the weakening effect gradually begins over 2-7 days and is not complete for two weeks. Therefore, optimal results are not seen for at least two weeks and sometimes longer. During this period you may notice asymmetry or unevenness within the treated areas. This asymmetry will usually correct itself as the Botox®/Dysport® takes effect. For maximal results, it is recommended that after receiving Botox®/Dysport® you maintain an upright posture for at least four hours. During this time it is also recommended that the treated area not be rubbed vigorously or massaged. Without touching, you may wish to frown, scrunch or wrinkle the treated areas during this time which may help to increase the response of the Botox®/Dysport®-targeted muscles.

There have been no long-term adverse effects or health hazards related to the use of botulinum toxin thus far. Muscle biopsy specimens have failed to show any evidence of permanent degeneration or atrophy. There are, however, several well known side effects that are temporary. These include the following:

- **Bruising.** Usually at or near the injection site, may be increased with the use of anti-inflammatories, aspirin or aspirin-like products including Vitamin E. This effect generally clears up within 7-10 days. No treatment is necessary.
- **Headache.** Related to the actual injections, is usually mild and transient lasting less than 24 hours. May be relieved with acetaminophen (Tylenol).
- **Pain at the injection site.** Similar to headache above, is usually mild, transient and relieved with acetaminophen.
- **Asymmetry.** As described above, if present, noticed within the first two weeks of therapy. May be corrected with "touch-up" injections if necessary.
- **Numbness.** Actually a change in sensation noticed by some Botox®/Dysport® patients in the treated areas. Better described as "dullness", it is usually only noticed for a few days after treatment. Treatment is not necessary.
- **Eyebrow or eyelid ptosis (drooping) and double-vision (diplopia).** Seen in 1-2 % of patients receiving Botox®/Dysport® therapy. It is temporary, lasting 2-4 weeks and is usually mild. May be treated with special eye drops.

Also, for reasons not fully understood, some patients may be less sensitive or "resistant" to the effects of Botox®/Dysport®. In these patients, Botox®/Dysport® will not work as well or as long as would ordinarily be expected.

If you are pregnant or breastfeeding, Botox®/Dysport® treatments are not recommended.

If you have a history of neurological (nervous system) disease, especially if it is currently active, you may not be a good candidate for Botox®/Dysport® therapy. This should be discussed with your treating neurologist or family physician prior to such treatment.

There are alternatives to Botox®/Dysport® therapy for wrinkles, including no treatment, topical cream treatments, chemical peels, laser peeling, surgical face lifting and surgical destruction of the muscles involved in the formation of dynamic lines.

Additionally,

The number of units injected is an estimate of the amount of Botox®/Dysport® required to paralyze the muscles. It can take up to two full weeks for the product to take full effect. If after the two week mark the desired results are not met, we will do a touch-up at a discounted rate.

I understand and agree that all services that are rendered to me are charged directly to me and that I am personally responsible for payment. I further agree I 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 agree that I have read and understand the above information and that my questions have been fully answered to my satisfaction. I accept the risks and complications associated with the procedure.

Printed Name:_____

Signed: _____ Date _____

Witness: _____ Date_____

Facial Aesthetics By Andrea
& Skin Care by Jamie E. Wade

During your office visit today we will be taking photographs of you for your medical Aesthetics record. We will photograph you through the course of your treatment(s) in order to demonstrate your progress, treatment results, specific concerns or disorder and subsequent therapy you are receiving. All photographs will be treated as confidential.

Occasionally we may find your specific results would be helpful to educate other patients in the practice.
If your photos are deemed useful, maintaining your privacy is vital to us and we will take measures to ensure your name and identity are not disclosed.

Any other uses of your photos such as for journals or publications would require written authorization from you to Facial Aesthetics by Andrea LLC, and/or Skin Care by Jamie E. Wade. We will at that time ask for authorization in writing so your photo can be used.

By signing this I, _____ give my consent to Facial Aesthetics by Andrea LLC, and/or Skin Care by Jamie E. Wade to use photographs of me for the purpose (s) of in office education only. I understand that this authorization is valid for all pictures taken during the course of my treatment(s). If at any time I wish to revoke this authorization I agree to notify Facial Aesthetics by Andrea LLC, and/or Skin Care by Jamie E. Wade.

Patient Name:_____

Patient signature:_____ Date:_____

FACIAL AESTHETICS BY ANDREA

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMAITON.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEATH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 03/01/2018, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEATLTH INFORMAITON We may use and disclose your health information for different purposes, including treatment, payment, and health care operations.

Treatment: We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment: We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing or credentialing activities.

Your Authorization. In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you make revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To your family and friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your in compacity or emergency circumstances, we will disclose health information based on a determination based on our professional judgement disclosing only health information that is directly relevant to the persons involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions. Medical supplies, x-rays, or similar forms of health information.

Marketing health/related services: We will not use your health information for marketing communications without written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We

may disclose your health information to the extent necessary to avert a serious threat to your health or safety or health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient under certain circumstances.

Worker's Compensation: We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards, letters or through an electronic system via email or text).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible.

Disclosure Accounting: With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official.

Right to Request a Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. We will not retaliate in anyway if you choose to file a complaint with us or with the U.S. Department of Health and Human Service.

Contact Officer: Amy Thrasher
Telephone #: 603-625-2193
FAX #: 603-669-9100
Address: 207 Meetinghouse Road
Bedford, NH 03110

Facial Aesthetics by Andrea
207 Meetinghouse Rd.
Bedford, NH 03110

Dear Patient,

In order for us to stay within the HIPAA guidelines, please list below anyone that you authorize us to disclose information to regarding your Protected Health Information. It is not mandatory that you list anyone. **(You do not need to list any of your doctors).**

	Name	**Relationship**
1.	_____	_____
2.	_____	_____
3.	_____	_____

Do we have your permission to leave information on your **answering machine** or **voicemail** if we are unable to reach you? ____ Yes ____ No

What is the best number to contact you at: _____.

_____ _____
Patient's Name (Please Print) Date of Birth

_____ _____
Patient or Parent/Guardian Signature Today's Date

HIPAA PRIVACY FORM 2

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
You May Refuse to Sign this Acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.
(Please Print Patient Name)

_____ _____
Patient or Parent/Guardian Signature Today's Date