WHITE SALMON FAMILY PRACTICE
INFORMED CONSENT

PATIENT

_____

DATE OF BIRTH

_____

ADDRESS

_____

_____

_____

Email_____

_____

PHONE

_____

TREATMENTS, PRODUCTS AND OR SERVICES RECEIVED:

Fillers: Botox ____ Juvederm Voluma XC ___ Volbella® XC _____
Chemical Peels : ViPeel ___ Skin Ceutical ____ _ Dermaplaning _____
Skin Resurfacing: Microneedling ____
Sculpting: Kybella _____

The purpose of this informed consent is to provide written information regarding the risks, benefits and alternatives of **your selected procedures named above**. If you have any questions regarding your procedure(s), Please Ask! PRIOR to signing the consent form.

DISCLAIMER:
By signing this consent***, I accept and understand that no treatment can be guaranteed 100%. I further understand that long term effects of any of the treatments that I may select below, are unknown.***

*****PLEASE INITIAL ONLY THOSE SERVICES THAT ARE PERTINENT TO YOUR TREATMENT TODAY.******

DERMAL FILLERS:

Voluma and Volbella:
Treatment with dermal fillers, such as Juvederm and Volbella can smooth out facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure, illness, etc. Dermal fillers are injected

under the skin with a very fine needle. This produces natural appearing volume under wrinkles and folds which are lifted up and smoothed out. **Initial ____**

BOTOX:
Botox is intended to treat moderate/severe facial wrinkles. Botox is FDA approved. Botox should not be used by patients with severe allergies and with a **history of anaphylaxis, pregnant or nursing, under the age of 18, in areas of active infection, or on immunosuppressive therapy**. I agree to post injection follow-up examination with Debra, at her request. Possible risks may include infection, bleeding, bruising, asymmetry, need for possible further correction, swelling or allergic reaction. **Initial _____**

RESURFACING:

MICRONEEDLING (Collagen induction):
Skin needling, also called microneedling therapy, collagen induction therapy (CIT), and percutaneous collagen induction (PCI), is a minimally invasive skin-rejuvenation procedure that involves the use of a device that contains fine needles. We are using "Mesopen" to administer treatment. The needles are used to puncture the skin to create a controlled skin injury. An interval of 4 to 6 weeks between treatments is typically recommended. Following the initial sessions of needling, We recommend doing maintenance treatments at intervals of 3 to 6 months. **Initial ____**

CHEMICAL PEELS (Vi Peel or Skin Ceuticals & Dermaplaning)

DERMAPLANING:
Dermaplaning can be performed every 3 to 4 weeks and removes dead skin cell buildup. **We recommend dermaplaning prior to any peels in order to better prepare the skin for treatments.** Dermaplaning is performed quickly and does not cause any pain. The procedure is designed primarily to remove vellous hair, the type of hair that is commonly referred to as 'peach fuzz.' Dermaplaning is not designed for people with acne or those who experience frequent breakouts. **Initial _____**

VI PEEL
Vi Peel is a Medical-grade chemical peel designed to address the signs of aging and common skin damage problems. Vi Peel can help reduce the effects of sun damage and reduce signs of melasma. The chemical reacts with the skin and causes skin to blister and peel off, thus removing the top layers of skin to allow new tissue to grow more easily. ***If you have a history of skin rashes, allergies, or other reactions to skin care treatments please discuss this with us BEFORE you start your chemical peel. It is very important that you discuss any history with cold sores, PRIOR TO THE APPLICATION OF VI PEEL, as this could lead to complications.*** We may be able to prescribe medication to combat these eruptions before attempting the Vi Peel treatment. **Initial____**

SKIN CEUTICALS MICROPEELS – "THE LUNCH-BREAK" PEELS
These Micropeels range from 10% to 30% and are suitable for even the most sensitive skin. The procedure combines manual and chemical exfoliation using glycolic acid and cryogenic therapy to reduce the appearance of fine lines, hyperpigmentation, laxity dullness and skin imperfections. **Initial____**

SCULPTING

KYBELLA:
Kybella Is a medical procedure used in adults to improve the appearance and profile of moderate to severe fat below the chin (submental fat), also called "double chin." You should not receive KYBELLA® if you have an infection in the treatment area. **Before receiving treatment tell us about all of your medical conditions, including if you:** Have had or plan to have surgery on your face, neck, or chin; have had cosmetic treatments on your face, neck, or chin; have had or have medical conditions in or near the neck area; have had or have trouble swallowing; have bleeding problems; are pregnant or plan to become pregnant); are breastfeeding or plan to breastfeed. Tell us **about all the medicines you take**, including prescription and over-the-counter medicines, vitamins, and herbal supplements. Especially let us know if you take a medicine that prevents the clotting of your blood (antiplatelet or anticoagulant medicine). This treatment **can cause serious side effects, including** nerve injury in the jaw (which can cause an uneven smile or facial muscle weakness), or trouble swallowing. **The most common side effects of KYBELLA® include** swelling, bruising, pain, numbness, redness, and areas of hardness in the treatment area. **Initial** _____

THE RISKS AND COMPLICATIONS

PLEASE READ THE FOLLOWING AND ASK QUESTIONS!

Before undergoing any aesthetic medicine procedure, understanding the risks is essential. ***No procedure is completely risk-free.*** The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. The potential associated risks and or side effects of my chosen procedures have been thoroughly explained to me.

By initialing this consent, I certify that any risks and/or potential side effects with my chosen treatment programs, may include but are not limited the following and have been thoroughly discussed with me:

1) Post treatment discomfort, swelling, redness, bruising, and discoloration;
2) Post treatment infection associated with any transcutaneous injections;
3) Allergic reaction;
4) Reactivation of herpes (cold sores);
5) Lumpiness, visible yellow or white patches;
6) Granuloma formation;
7) Localized necrosis and/or sloughing, with scab and/or without scab if blood vessel occlusion occurs.
8) Hyperpigmentation
Initial ____

CONTRAINDICATIONS

By signing this consent form I certify that **I AM CURRENTLY NOT**:
***Pregnant or lactating**
***Undergoing chemotherapy and/or radiation therapy**
***Experiencing active autoimmune diseases or conditions that may weaken my immune system**. **Initial _____**

By signing this consent form I certify that **I HAVE NOT:**
*Taken Aspirin, hydroquinone or had any phenol allergies within the last _____ days.
*Used Accutane within the past 3 months
*Recently experienced active cold sores, warts or open wounds. **Initial _____**

By signing this consent form I certify that I:
***Have NO history of HSV (Herpes Simplex Virus) (If you do…PLEASE TELL US " BEFORE" ANY TREATMENT).**
*Have no neuromuscular disease
*Have had no previous adverse reactions to Botox
*Have no known allergy to egg whites or albumin
*Have no open sores or infections within the are to be injected
*That I have disclosed any amount of Botox I have received within the previous 3 months (it is recommended that patients to DO NOT exceed more than 360 units over a 3 month period) **Initial _____**

PREGNANCY AND ALLERGIES (For fillers, botox and skin peels)

I am not aware that I am pregnant. I am not trying to get pregnant. I am not lactating (nursing). I do not have or have not had, any major illnesses which would prohibit me from receiving dermal fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine. Initial ____

PATIENT RESPONSIBILITIES

I understand that the success of aesthetic medical treatments requires my participation and cooperation to ***FOLLOW POST-TREATMENT PROCEDURES EXACTLY AS INSTRUCTED. THOSE INSTRUCTIONS MAY INCLUDE (BUT NOT BE LIMITED TO): The following are generally associated with Vi Peel Skin Peels.***
*NOT TO PICK OR RUB EXFOLIATING SKIN
****To use only skincare products discussed by my provider as an approved follow-up treatment***
*To avoid extended direct sun exposure including tanning beds before and after treatment for at least _____ days.
****To use SPF 50 product approved by my provider for at least _____ days following treatment.***
*To not receive any other chemical peels or medical device treatments until after _____.
Initial _____

PAYMENT

I understand that my chosen aesthetic medical treatments are elective. Payment is my responsibility, is non-refundable and is expected at the time of treatment.

INDEMNIFICATION

I hereby indemnify White Salmon Family Practice from any liability relating to the treatments and or products that I have requested. I also understand that any treatment performed is between me and my healthcare provider who is treating me and I will direct all post-procedure questions or concerns to Debra Short. Initial____

(OPTIONAL) Photography

I authorize the taking of photographs and or videos and their use ONLY within the Practice for reference purposes with other WSFP patients. I agree to hold White Salmon Family Practice, harmless for any liability resulting from sharing my photo with other WSFP patients.
Initial ____

CERTIFICATION

I have read the above and understand it. My questions have been answered

satisfactorily. **I accept the risks and complications of the treatments(s) I have selected and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.**

_____

_____Patient Name (Print) Patient Signature

Date

I am the treating healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

DEBRA A SHORT, MSN FNP BC_____

Provider Name (Print) Provider Signature Date