WHITE SALMON FAMILY PRACTICE
INFORMED CONSENT

PATIENT _____

DATE OF BIRTH _____

ADDRESS

_____

_____

Email_____

PHONE _____

TREATMENTS, PRODUCTS AND OR SERVICES RECEIVED:

Botox _____ Juvederm Voluma XC ___ Ultra XC___ Chemical Peels : ViPeel __ Skin Ceutical ____ %
Microneedling _____ Dermaplaning _____

The purpose of this informed consent is to provide written information regarding the risks, benefits and alternatives of your selected procedures named above. This material serves as a supplement to the discussion we have had regarding health risks, expectations and results. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding your procedure(s), Please Ask! PRIOR to signing the consent form.

THE AESTHETIC TREATMENTS

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.

DERMAL FILLERS:

Treatment with dermal fillers, such as Juvederm 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. Facial rejuvenation can be carried out with minimal complications. These 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. The results can often be seen immediately. **Initial ____**

COLLAGEN INDUCTION (MICRONEEDLING)

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. Each puncture creates a channel that triggers the body to fill these microscopic wounds by producing new collagen and elastin. Through the process of neovascularization and neocollagenesis, there is improvement in skin texture and firmness, as well as reduction in scars, pore size, and stretch marks. 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

Vi Peel is a pharmaceutical-grade chemical peel, that is produced by Vitality Institute Medical Products, a manufacturer of medical-grade skin care treatments that are meant 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 main thrust of the Vi Peel is an attempt at reducing the pain and discomfort commonly associated with chemical peels, although results vary between patients. As with any facial chemical peel, Vi Peel works when the product is used evenly across the skin. The chemical reacts with the skin and creates micro damage that causes skin to blister and peel off, thus removing the top layers of skin to allow new tissue to grow more easily. The damage caused to the skin on the one hand removes older skin cells, and at the same time helps stimulate collagen production, in order to heal the skin faster. One of the differences between a Vi Peel and other chemical peels is that Vi Peel contains an anesthetic. Patients using Vi Peel usually report feeling a stinging sensation at the beginning of peel, which tends to subside when the anesthetic sets in. 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. ViPeel is recommended seasonally. **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. There is NO down time and can easily be done during the day with patient able to return directly to normal activities.

DERMAPLANING:

Dermaplaning can be performed every 3 to 4 weeks and typically removes several weeks of dead skin cell buildup. The Treatment is performed quickly and does not cause any pain. Dermaplaning is designed primarily to remove vellous hair, the type of hair that is commonly referred to as 'peach fuzz.' While dermaplaning offers several benefits, there are also some drawbacks to this procedure. People with very sensitive skin may not be good candidates for this procedure because it is among the more aggressive skin exfoliation and rejuvenation treatments available. The skin may peel naturally after the procedure, especially if you are undergoing the treatment every two to three weeks. This means you will need to use an emollient-rich moisturizer day and night as the peeling process begins, and ensure that the skin does not get too dry. Dermaplaning is not designed for people with acne or those who experience frequent breakouts because it can trigger over activity of the sebaceous glands. When someone has acne, they need their vellous hairs to expunge the oil that typically builds up under the skin. If the vellous hairs are removed because of the dermaplaning procedure, the individual may experience more breakouts and even more severe acne. **Initial _____**

BOTOX

Botox is intended to treat moderate/severe facial wrinkles. Botox is FDA approved. There are certain areas of injection that are considered off-label use. 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. I understand that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either to the success or other result of the treatment. Possible risks may include infection, bleeding, bruising, asymmetry, need for possible further correction, swelling, allergic reaction. Bacterial or viral infections at the site are rare but may occur. As with any injection, into the head or neck, the injected material may be inadvertently implanted in a blood vessel, which could cause occlusion, infarction or embolic phenomena. Reabsorption of the implant will occur. **Initial _____**

THE RISKS AND COMPLICATIONS

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 related to 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.

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

By signing this consent form I certify that I:
*Do not have a history of HSV YES_____ NO_____
*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

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 ____**

ALTERNATIVE PROCEDURES

Alternatives to my selected procedures and options have been fully explained to me. **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):

*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. If I have opted for a "package" of services and or products, in order to receive a discounted rate, I agree to keep my contracted appointments within the time frame specified (generally within 12 consecutive months) **Initial ____**

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-operative questions or concerns to the treating clinician. **Initial____**

(OPTIONAL) PUBLICITY MATERIALS

I authorize the taking of clinical photographs and or videos and their use for scientific and marketing purposes both in publications and presentations. During treatments, I understand that photographs and or video may be taken of me for educational and marketing purposes. I hold White Salmon Family Practice, harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspection of the finished production as well as advertising materials in conjunction with these photographs.

Initial ____ I agree to photographs as discussed above: ____ I do not agree to photographs as discussed above:___

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 and was offered a copy of this informed consent. 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