# COSMETIC INTEREST QUESTIONNAIRE

## CONTACT INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PH: _____ CELL: _____ E-MAIL: _____

**For the following statements, please circle the number that best reflects your opinion, with 1 as agreeing the least and 5 as agreeing the most.**

Which phrase best describes your skin type?

__ I- always burns, never tans
__ II-always burns, sometimes tans
__ III- sometimes burns, always tans
__ IV- rarely burns, always tans
__ V- moderately pigmented (Hispanic, Asian, Mediterranean, Middle Eastern)
__ VI African American

1. If effective, non-surgical options were available to successfully correct my lines and wrinkles, I would be interested. __yes __no
2. Do you have a history of keloids or unusual scarring? __ yes __ no
3. Do you have a history of Herpes simplex (fever blisters, cold sores) recurring in the area to be treated? __ yes __ no
4. Have you been on Accutane (isotretinoin) in the last six months? __ yes __ no
5. Do you use Retin-A, Renova, Differin, glycolic acid products or hydroquinone (bleaching agent) on the treated area? __ yes __ no
6. Have you had waxing, plucking or electrolysis performed on the area(s) to be treated in the preceding six weeks? __ yes __ no
7. When were you last exposed to the sun (including tanning booths)? _____
8. Do you use sunless tanning lotions? __ yes __ no When was it last applied? _____
9. Are you pregnant? __ yes __ no
10. Please list any medications, including hormones, you are currently taking:
    _____
11. Please list any medication allergies: _____
12. Have you ever had permanent make-up (eyeliner, lip liner, blush, eyebrow color)? __ yes __ no If so where? _____
13. Do you have any tattoos (medical, cosmetic, decorative, or traumatic) in the area to be treated? __ yes __ no If so where? _____
14. Have you ever been checked for hormone, thyroid problems or have you ever been seen by an endocrinologist? __ yes __ no
15. What products are you currently using on your skin in the area you wish to be treated?
    _____
16. Have you ever had a cosmetic laser treatment or laser hair removal? If so what type and when?
    _____
17. Do you have Lupus? ___ yes ___ no

# CONSULTATION AND TREATMENT PLAN

**AREAS OF INTEREST:** Sometimes the best results can be achieved by using multiple treatment methods regarding areas of concern. Radiance, clarity and smooth texture are the hallmarks of youthful skin, though over time, the effects of aging and sun exposure can take their toll. They result in skin imperfections such as wrinkles, fine lines, sunspots, uneven skin tone and skin laxity.

## (PLEASE CHECK ALL AREAS OF CONCERN & YOUR INTERESTS)

- ○ Skin-care advice or Consultation
- ○ Skin Rejuvenation & Tightening
- ○ Skin Resurfacing
- ○ Acne Treatment
- ○ Tattoo Removal
- ○ Nail Fungus Removal
- ○ Psoriasis Treatment
- ○ Birthmark Correction
- ○ Hyperpigmentation/ Spot Correction
- ○ Leg vein Removal
- ○ Hair Removal
- ○ Vein Removal
- ○ Scar Reduction
- ○ Other (Please Specify): _____


# CLEARLIFT BY HARMONY XL PRO
## (SKIN TIGHTENING AND REMODELING TREATMENT)

### WHAT IS IT?

ClearLift is one of Harmony XL Pro most popular and comprehensive Q-Switched Nd:YAG treatment solution available today. It is known as the Laser FaceLift treatment, Collagen booster, 'Lunchtime Procedure'. ClearLift is safe and effective even for thin and delicate areas of the skin.

### WHAT DOES IT DO?

*Treats: (wrinkles, fine lines, photo-damage, uneven skin tone and skin laxity)*
ClearLift uses a specially designed fractional Q-Switched laser to achieve a deep mechanical effect, focusing the energy beneath the epidermis. This creates a controlled dermal wound while leaving the epidermis intact. The wound healing process stimulates growth of new collagen as well as contracture and tightening of the tissue.

I _____, have chosen the following treatments listed.

- ○ Skin Remodeling with *ClearLift Plus*
- ○ Vascular Lesions with our *YAG Laser*
- ○ Pigmented Lesions with *ClearLift Plus and Q-Switch YAG Laser*
- ○ Tone and Texture with *iPixel YAG Laser*
- ○ Tattoo Removal- *Q-Switch Laser*
- ○ Hair Removal- with *AFT Technology with SHR Method*
- ○ Acne Treatment with *AFT Technology*
- ○ Toe Fungus Treatment with *Q-Switch YAG Laser*

### FOLLOW-UP TREATMENT PLAN:

- ○ Patients should return in _____, for additional treatment, if necessary. Treatment intervals: 2-4 week intervals.
- ○ Treatment is complete when *satisfactory results are obtained.*
- ○ Patients should be instructed to *avoid sun exposure* after and in between treatments.

**TOTAL TREATMENTS RECOMMENDED: _____**

**Patient name (printed)** _____ **Date:** ____/____/_____
**Patient Signature:** _____

# LASER TREATMENT CONSENT TO TREAT

This form is designed to provide you with the information you need to make an informed decision on whether or not to have the Laser Treatment procedure performed. If you have any questions or do not understand any part of this consent, please do not hesitate to ask us.

I _____, have chosen the following treatments listed.

- Skin Remodeling with *ClearLift Plus*
- Vascular Lesions with our *YAG Laser*
- Pigmented Lesions with *ClearLift Plus and Q-Switch YAG Laser*
- Tone and Texture with *iPixel YAG Laser*
- Tattoo Removal- *Q-Switch Laser*
- Hair Removal- with *AFT Technology with SHR Method*
- Acne Treatment with *AFT Technology*
- Toe Fungus Treatment with *Q-Switch YAG Laser*

*The Skin Evaluation and Consultation Form reflect the chosen areas I wish to receive my treatment.* ____***Initial***

- TO PROVIDE TREATMENT: *We will use your HPI within the office to provide you medical treatments. This may include administrative, clinical and office procedures designed to optimize scheduling/coordination of care between the physician and/or staff handling your care.*
- TO OBTAIN PAYMENT: *We will use your HPI with an invoice, used to collect payment for the treatment you receive here. HPI will be used on Credit Applications or Other Third Party Financing forms sent by mail or electronically.*
- IN PATIENT REMINDERS: *Phone calls to remind you of a upcoming appointment or situations will be necessary. Additionally, we may also use electronic methods to contact you such as email, text message, by phone, online patient accounts, postcards, letters, statements, etc. These methods of communications help optimize our office workflow.*
- PUBLIC HEALTH/NATIONAL SECURITY: *We may be required to disclose to federal/ military officials or other authorities, if HPI is necessary to complete an investigation related to public health or national security. HPI is important to the government if they believe that public safety could benefit from, control or prevent an epidemic.*
- PHOTOGRAPHS- If Pre and Post-Treatment photos are taken of the treatment for record purposes; I understand that these photos will be property of Dr. Curtis Story. I understand that these photos may be used for diagnostic, educational, or record keeping purposes.

*I understand the Story Family Medicine (HIPAA Consent to Treat):* _____ **Initial**

# DISCLAIMER AGGREEMENT

- CANCELATIONS- We request the courtesy of a 24-hour notice in the event an appointment needs to be canceled or rescheduled. A $30 no-show fee for Laser will apply in the event that an advanced cancellation notice is not given.
  FINACIAL RESPONSIBILITY-Any fees agreed to, are due upon time before the first treatment is rendered:
  For Non Credit Applicants, we require payment in full in order to schedule your treatments. We accept Cash, Visa, Mastercard, Visa, American Express and Discover.
- LIMITED GUARANTEES- Because all individuals are different, it is not possible to completely predict the benefits from the laser treatment. Limited guarantees can be made concerning the results of the treatment. Some patients will have a very noticeable improvement, while other may have little or minimal improvement. Optimal results are achieved by *completing a series of treatments*, as you will probably not see results after only one treatment.
- LACK OF PERMANENT RESULTS: Treatments may vary among patients. For some this may mean a significant decrease in the frequency with which you may continue other daily regimens. For others it may mean better cosmetic improvement because of combination of treatments used., If HAIR REMOVAL- Everyone will experience hair regrowth over time, regardless of the technology used. Hair that grows back will tend to be finer, lighter and less dense.
  ACKNOWLEDGEMENT-I understand and acknowledge that payments for the above named procedure(s) are non-refundable for each treatment session received. _____ **Initial**

By my signature, I acknowledge that I have read the foregoing informed consent form, waiver of liability and disclaimer agreement and have been adequately informed of the expected benefits of treatment, risks of the treatment, alternative methods of treatment. I hereby consent to the chosen treatment.

**Print Name:** _____ **Date:** _____

**Patient Signature:** _____

# INFORMED CONSENT FOR LASER THERAPY - LIABILITY WAIVER AND RELEASE

I _____, understand that a **LASER** is being used for my treatment. Although laser therapy is safe and effective in the majority of cases, unexpected adverse events may occur. Unexpected side effects may result from the use of the laser & the expected response of the treated area may not be achieved.

- **Short term effects:** I understand that there are multiple short term effects that may occur, including reddening, irritated raised rash, mild burning, swelling, bruising, numbing, temporary pigmentary change, blistering, scabbing, crusting, flaking & sensitivity to the sun. Although these effects typically resolve within several days, they may persist for several weeks and rarely, even longer. I understand that the degree of the side effects varies from person to person, and it may not be possible to predict how I will respond.
- **Possible permanent effects:** I understand that although most side effects are short term and resolve fairly quickly, some effects may be permanent. Scarring, changes in pigmentation & hair loss may be permanent.
- **Discomfort associated with procedure:** I understand that the laser functions by heating up its target (blood vessels, pigmentation). This heating sensation is minimized by the use of the cooling piece, but some level of discomfort may be felt. The level of discomfort depends on the treatment being done, and varies from person to person. The stinging or sensation of heat is typically short but may persist for several hours after the procedure.
- **Effects of UV:** I understand that sun exposure, tanning beds, sunless tanning lotions, and tanning creams can cause discoloration or reaction to laser treatment during and after the procedure. Having any kind of tan prior to therapy or soon after therapy results in an increased chance of blistering, permanent or temporary discoloration, scarring, and discomfort. I understand that avoidance of any UV exposure 1 month prior and 2 weeks after treatment reduces the risk of these effects.
- **People excluded from therapy:** I understand that certain patients should not have laser treatment. This includes any patients who have open wounds, malignant skin tumors, patients who have certain disease that make them sensitive to light, patients currently on Accutane (Isotretinoin) or who have been on Accutane within in the last 3 months, and in many cases, patients who have tattoos.
- **Need for multiple treatments:** I understand that some conditions being treated by the laser may require multiple treatments to obtain the desired results. Everyone responds in different ways and different rates to the treatment.
- **Tattoo/permanent makeup:** If there are any tattoos or permanent makeup in the area, there is a possibility of blistering and lightening of the tattoo/makeup.
- **Photographs:** I understand photos or video of my treatment may be taken. These may be used for teaching health professionals or shown for scientific reasons. I will NOT be identified in any photo or video.
- **For laser vein treatment:** I understand that this procedure involves a laser to coagulate the vessels and a bruising effect could last up to 6 months. It is possible the results will be minimal or not help at all. I realize that each individual's treatment response is different; therefore it could require multiple treatments to achieve desired results. Other options are available, and may include sclerotherapy, surgery or no treatment.
- **I agree to wear proper eyewear.** Eye injury due to use of the laser is a risk to the patient and to the clinician; however, the risks are almost completely eliminated with the use of proper eyewear.
- **I understand that this procedure is elective** & there are other options for treatment including no treatment.
- I understand that my insurance company will **not** cover the cost of laser therapy, and I am responsible for the complete cost of the service. Payment is due at the time of the treatment unless other arrangements have been made in advance. I also understand that once I have started my treatment program, there are no refunds.

**Dr. Curtis Story MD** has explained the nature and purpose of the laser treatment, including any risks and possible complications. The contents of this form has been discussed and explained to me. I have read and understand this consent form & I agree to its terms and authorize treatment. I do hereby waive, release, absolve, indemnify and agree to hold harmless Dr. Curtis Story MD for my individual treatment results.

**I further understand that results CANNOT be guaranteed.**

**Patient Name (PRINTED)** _____ **Date:** _____

**Patient Signature:** _____

# STORY FAMILY MEDICINE

## LASER TREATMENT
## Deposit & Payment Plan

NAME: _____

DOB: _____

PH: _____

TOTAL PRICE OF TREATMENT: _____

TODAY'S DEPOSIT: _____

BALANCE DUE DAY OF APPT: _____

Method of Payment: __ Cash
__ Credit Card
__ CareCredit

CareCredit Account # _____

CC#: _____

EXPIRATION DATE: _____ SECURITY CODE: _____

Next Appointment Date:

_____

Appointment Time:

_____

Length of Appointment:

_____

I have read, initialed, and understand the Laser Treatment Questionnaire, Home Care + Consent and the Deposit Agreement.

SIGNATURE: _____

DATE: / /

Consultant Signature _____

DATE: / /

## FOR STAFF ONLY:

(Recommendations and discussions with provider)

- **COSMETIC QUESTIONAIRE**
- **CLIENT CONSENTS**
- **CLIENT EXPECTATION, CONSULTATION & TREATMENT PLAN:** (understands need for multiple treatments, after care, possible side effects, etc.) Importance of sun exposure avoidance and the use of a broad-spectrum zinc oxide or titanium dioxide
- **FULL TREATMENT SCHEDULE PROCESS** (waiting period in-between treatments, expected results., etc.
- **POSSIBLE SIDE EFFECTS** (Waiver of Liability) (hyperpigmentation, hypopigmentation, purpura, scarring, textural changes, burns, blistering, pain or discomfort and erythema) and length of time to expect healing if side effects occur.
- **SKIN TEST:** Specifics of area to be treated. Test small area for tissue response BEFORE full treatment.
- **CLIENT COMFORT:** Note sensation of the laser/DCD spray and the option for topical anesthesia or other cooling methods.
- **BENEFITS:** Benefits of laser treatment (long-term hair removal), improvement in skin, etc.
- **COST OF TREATMENT** (Payment Plan, Cost of multiple treatments versus single payment per visit).
- **PATIENT SAFETY:** Eyewear protection and laser safety measures required for patient and provider. Patients may sense light while wearing proper eye protection. Patient must verbalize sensation during treatment.
- **CLIENT MATERIALS:** Importance of post care instructions/procedures.

  **(**Patient given copies of treatment plan).

  **PHOTO TAKEN TODAY: _____ YES _____NO**

  **COMMENTS**: _____