Fibroblast Packet

Legacy 41

Date:		**Date of Birth:**	**Sex:** Male Female
Name:			
Address:			
	City:	State:	ZIP:
Phone:	Mobile:	Home:	Work:
Email:		**Occupation:**	
EMERGENCY CONTACT: Name:		**phone:**	**Relationship:**
How were you referred to us?			
Do you regularly sunbathe or use tanning beds?		**How often?**	

Personal and Medical History (All information is confidential and needed to provide the most appropriate treatment.)	yes	no
Are you over the age of 18?		
Are you in good health?		
Are you under the care of a physician? If yes, for what?		
Do you feel fit and well enough to have a fibroblast procedure?		
Are you under the influence of drugs or alcohol?		
Have you or are you planning to have any injectables, fillers, or chemical peels in the near future?		
Have you had AHA, glycolic products, Roaccutane, or gold therapy in the last 30 days?		
Do you have any imminent holiday or otherwise celebratory plans in the near future?		
Do you knowingly suffer from any active infection?		
Do you knowingly suffer from any infectious disease?		
Do you suffer from epilepsy?		
Do you suffer from heart problems?		
Do you suffer from high or low blood pressure?		
Do you suffer from diabetes?		
Do you have any respiratory problems?		
Do you suffer from dizziness or fainting attacks?		
Do you suffer from seizure disorder?		
Do you suffer from lupus?		
Do you suffer from HIV/AIDS?		
Do you have any auto-immune disorders or are you immune deficient?		
Do you suffer from any imbalances, such as hormone or thyroid?		
Do you suffer from hepatitis?		
Do you suffer from cancer or are you receiving chemotherapy or radiation treatments?		
Do you have any lymphatic problems?		
Do you suffer from hemophilia or other blood clotting abnormalities?		
Do you suffer from any skin ailments such as eczema, psoriasis, vitiligo, etc. or other skin disease or lesions?		
Do you have any open wounds or severe acne?		
Do you have any problems with scar healing, such as keloid or other issues?		
Do you suffer from herpes?		
Do you suffer from recurrent cold sores?		
Do you suffer from arthritis?		
Do you suffer from any other health problem or medical condition not listed?		
Please list any condition not mentioned:		
If you suffer from any of the above, it is important that you notify your specialist so that the necessary precautions can be taken to ensure you receive the best treatment and avoid potential risks to your health.		

I understand the importance of my accurate and complete medical history. I understand that withholding any medical information may be detrimental to my health and safety during and after treatment. I understand that if there is any change in my medical history it is my responsibility to inform the specialist.

Client signature:_____Date:_____ Specialist signature: _____Date:_____

Additional Medical History:

Name: _____

Medications:	yes	no
Are you currently taking any medications? If yes, it is required that you list all of them:		
Are you taking birth control or other hormone therapy medications? If yes, please list:		
What antibiotics do you most commonly use to treat infections?		
Are you taking any medications for heart conditions?		
Are you on any mood altering or antidepression medication?		
Are you currently using any topical medications or creams such as Retin A or others? If yes, please list:		
What, if any, herbal supplements do you use regularly?		

Allergies:	yes	no
Have you ever had an allergic reaction? If yes, please describe:		
Do you have an allergy to any medical products such as latex gloves, adhesive tape, etc.? If yes, list:		
Do you have an allergy to aspirin?		
Do you have an allergy to penicillin?		
Do you have an allergy to hydrocortisone?		
Do you have an allergy to hydroquinone?		
Do you have an allergy to lidocaine?		
Do you have allergies to any other medications? If yes, please list:		
Do you have any food allergies? If yes, please list:		
Do you have an allergy to animal protein?		
Do you have an allergy to skin bleaching agents?		
Do you have any other allergy not listed above? If yes, please list:		

For our female clients:	yes	no
Are you pregnant or trying to become pregnant?		
Are you breastfeeding?		
Are you using contraception?		

Additional notes:

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 doctor or other health professional of my current medical health or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Client signature: _____ Date: _____

Name: _____

Fibroblast Skin Tightening CONTRAINDICATIONS:

Contraindications are certain conditions or situations that would make treatment inadvisable. Contraindications for Fibroblast Skin Tightening treatment include the following:

- Pregnancy / breastfeeding
- Metal pins or plates near the area to be treated
- Pacemakers
- Severe cardiovascular disorders
- Cancer patients
- Diabetes
- Uncontrolled blood pressure
- Colds
- Blood disorders
- Auto immune diseases
- Epilepsy
- Pigmentation disorders
- Fitzpatrick types 5 & 6
- Keloid scarring
- Lupus
- Herpes simplex
- Infections
- Psoriasis
- Shingles
- Vitiligo
- Active eczema
- Active severe acne
- Accutane
- Retinal
- Allergies to lidocaine

Fibroblast Skin Tightening is not suitable for everyone. There are risks associated with the treatment and it is of the utmost importance to know if you are a candidate for this advanced procedure.

If you are considering Fibroblast Skin Tightening, you should be in good health at the time of your appointment with no preexisting health conditions. Ideal candidates for this cosmetic procedure are those with lax, crepe-like skin around the eyes, mouth, neck, stomach, or other targeted area for treatment.

Fibroblast is inadvisable for the following:

- If you are prone to keloid scarring
- If you have diabetes, healing disorders, or lymphatic draining issues
- If you have a history of hyperpigmentation
- If you have a pacemaker
- If you are pregnant or breastfeeding
- If you have a dark complexion as indicated on the Fitzpatrick Skin Type Scale. This treatment is recommended for light to medium skin tones as darker complexions are at risk for hyperpigmentation.
- If you are displaying signs of herpes simplex virus (cold sores/fever blisters)
- If you are experiencing any signs of cold or flu
- If the area to be treated is inflamed in any way
- If you have applied any AHA and or retinol products less than 30 days prior to scheduled treatment
- If you have applied any cleansers, creams, or serums containing acids (salicylic, glycol, & lactic) less than 30 days prior to scheduled treatment
- If you are having treatment in the area of the eyes and have lash extensions (they must be removed and not reapplied for 8 weeks after treatment)

Please sign to indicate you understand the contraindications to Fibroblast treatment as stated above:

Client signature: _____ Date_____

Fibroblast Skin Tightening Treatment Plan:

Name: _____

	yes	no
Have you ever received skin tightening treatments before?		
If yes, how long ago?		
If yes, at what location did you have the procedure?		
Please list the type of procedure, areas that were treated, and whether or not you were pleased with the results:		

TREATMENT PLAN: This part of the consultation record is to be completed by the specialist in order to record important elements of the treatment. This form must be kept with the client's medical and consent forms.

THE SPECIALIST WILL USE THIS FORM TO RECORD THE TREATMENT OF ONE AREA ONLY. ALL ADDITIONAL TREATMENT AREAS WILL BE RECORDED ON SEPARATE TREATMENT PLAN FORMS.

THE FITZPATRICK SKIN TYPE SCALE

TYPE 1	TYPE 2	TYPE 3	TYPE 4	TYPE 5	TYPE 6
Light, Pale White	White, Fair	Medium, White to Olive	Olive, Moderate Brown	Brown, Dark Brown	Black, Very Dark Brown to Black
Always burns, never tans.	**Usually burns, tans with difficulty.**	**Burns mildly, tans gradually.**	**Rarely burns, tans with ease.**	**Very rarely burns, tans very easily.**	**Never burns, tans very easily.**

Fibroblast Skin Tightening can only be performed on Skin Types 1, 2, 3, and 4.

Indicate the Fitzpatrick Skin Type Scale above and circle the client's skin type: 1 2 3 4 5 6

What is the agreed upon treatment and how many visits will it take to achieve? (First visit only)

_____

_____

Treatment area(s) being completed:

_____

_____

Treatment area _____. Treatment number _____of _____ recommended treatments (up to four per area).

What is the predicted outcome and recommendations?

_____

_____

_____

_____

Notice of Privacy Practices:

Name: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW.

I am required by the Health Insurance Portability & Accountability Act of 1996 (HIPPA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in my possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by Legacy 41, and of your individual rights and Legacy 41's legal duties with respect to confidential information.

Ways in which I may use and disclose your protected Health Information:

I may use and disclose at my discretion your medical records for each of the following purposes only:

- **Treatment** means providing, coordinating, or managing mental health care and related services.
- **Payment** means activities such as obtaining payment for the health care services I provide for you from your insurance or another third party payer.
- **Health Care operations** include the business aspects of running a practice.

I may contact you to provide appointment reminders or other services that may be of interest to you. I will disclose your protected heath information to any person you identify that is involved with payment for your care.

I will use and disclose your protected health information when required by federal, state, or local law. There are certain situations in which as a therapist I am required by ethical standards to reveal information obtained during therapy to persons or agencies even if you do not give permission. These situations are as follows: (a) If you threaten grave bodily harm or death to yourself or another person, I am required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report to me your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, I am required by law to inform the appropriate child welfare or social agency which may then investigate the matter; (c) if I am required by a court of law (court order) to turn over records to the court or if I am ordered to testify regarding those records.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke authorization in writing as I am required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

RELEASE OF INFORMATION: I authorize the release of information including diagnosis, records, examination rendered to me, and claims information to the following (please "X" out the box if information is not to be released).

Name	Relationship	Phone

Voice mail messages can be left on the number(s) indicated below (leave blank for no message):

Mobile: Home: Work:

Please sign below to indicate you understand my operation use of your information for treatment, payment, and health care operations as stated above:

Client signature:_____ Date:_____

Fibroblast Skin Tightening Consent Form:

Name: _____

You are required to complete and sign this consultation record prior to treatment thereby giving your consent to treatment.

Your specialist will discuss the procedure in full; including the benefits, the risks, and the healing process as well as advise you about any additional treatment, if necessary. On completion of the treatment, you will be given written aftercare information for you to keep and refer to during the healing process.

It is important that you clearly mark any areas of this form you wish to have clarified or to further discuss. It is ultimately YOUR responsibility to ensure you fully understand the procedure and the expected outcome prior to treatment.

PLEASE READ CAREFULLY AND SIGN WHERE INDICATED only when you are happy to proceed.
You are signing to state that you understand and accept these terms.

TERMS OF TREATMENT:

- You have chosen a cosmetic procedure that is not medically necessary.
- Fibroblast is an effective skin tightening technique. Nonetheless, it is an art process, not an exact science, and a precise result cannot be guaranteed due to individual skin elasticity and healing process variability.
- Any results from Fibroblast treatment are permanent and may be visible for years. However, the aging process is continuous. Your skin ages every day, both before and after treatment. This cannot be stopped.
- Your specialist will use a treatment plan to record the area treated and the anesthetic and probe used. Pre and post procedure photos will also be held securely in the consultation record.
- The treatment includes small burns to the skin, which often causes a charring smell and sometimes smoke; this is normal.
- Some swelling and redness may occur after treatment. Some experience more than others. It is expected as the skin is recovering from deliberate controlled wounds. Your specialist will provide suggestions on how to reduce the risk of swelling and redness.
- You must let the treated area heal properly by following the aftercare instructions given to you by the specialist to ensure the best possible outcome and to avoid risks of postprocedural infection upon leaving the treatment center. Avoid picking, peeling, plucking, or otherwise manipulating the treated area as this will hinder the healing process and could lead to need for more work.
- On occasion the healing process may lead to some discoloration of the skin. Microdermabrasion, chemical peel, or other skin rejuvenation may be advised AFTER healing is complete.
- You may be required to return for additional treatments before the overall procedure is deemed complete, or your desired result is achieved. Additional treatment (and consultation regarding additional payment) can be scheduled 6 to 8 weeks after the previous treatment in order to maximize results and reduce chances of hyperpigmentation.
- Be aware that skin altering procedures such as plastic surgery, implants, injectables, and weight gain or loss may alter the fibroblast results.
- PAYMENT IN FULL is due at the time of the procedure.

I understand that my specialist will be in direct contact with me in relation to the fibroblast treatment. This treatment involves the use of a disposable probe. All other equipment and surfaces are sterilized before use. The specialist will wear gloves during treatment. I consent to receiving FIBROBLAST SKIN TIGHTENING treatment. My specialist has explained the terms and conditions of treatment and I fully understand. I hereby give written consent to the specialist, who is fully trained and insured, to carry out the treatment of my choice as requested by me on this consent and treatment agreement.

Name: _____

TREATMENT AREA / PACKAGE: _____

PRICE AGREED: _____ FORM OF PAYMENT: _____

COMMENTS: _____

_____

Client signature:_____ Date: _____

Specialist signature_____ Date_____

Name: _____

Fibroblast Skin Tightening PATCH TEST Form:

- I understand that a skin test can determine whether I will experience a reaction to the products used by the specialist within 48 hours prior to treatment. However, I accept this will be inconclusive as to whether I will have an allergic reaction at any time in the future. I therefore **waive** my option to an allergy test and wish to proceed with treatment. (initial here) _____

- I **want to undergo or have been offered** an allergy test prior to my initial treatment. I therefore release the specialist from liability related to any allergic reactions I may experience associated with either the application of pretreatment cream or any products used after the procedure, immediately or at a later date. (initial here) _____

I understand the above and **wish to waive** the patch test. (initial here) _____

I understand the above any **wish to have** a patch test performed even though I acknowledge it will be inconclusive at any time in the future. (initial here) _____

Client signature: _____ Date: _____

Please note:

- If you are waiving the patch test, please initial the two bulleted explanations as well as the "wish to waive" line.
- If you want to have the patch test, please initial the second bulleted explanation and the "wish to have" line.

Patch Test:

Date administered: _____

Date of recheck: _____

Comments regarding outcome of patch test: _____

Client and specialist agree to commence fibroblast treatment. (circle one) YES NO

Date of treatment, if any: _____

Client signature: _____ Date_____

Specialist signature:_____ Date: _____

Name: _____

Fibroblast Skin Tightening PHOTOGRAPHIC Consent Form:

Photographs of the treatment area will be taken BEFORE, DURING, and AFTER the procedure. Please initial each bullet and sign below to demonstrate your acceptance of these terms.

- I agree to these photographs being stored confidentially in my case-file/treatment plan. (initial here)_____
- I agree to these photographs being used for promotional purposes. (initial here)_____

Aesthetics Client Informed Consent:

Plasma soft surgery treatment, Fibroblast, is a procedure that can only be performed by a specifically trained and qualified specialist using approved equipment to shrink the skin using sterile disposable probes.

Contraindications will be recorded on this consultation form, which will be used as a reference in the future.

I voluntarily request that Legacy 41 (and such associates, technical assistants and other skin care professional deemed necessary) to perform plasma soft surgery treatment, Fibroblast. I acknowledge having been informed that this cosmetic procedure is intended to_____.

I understand that my skin care professional can discover other, or different conditions, that may require additional or different procedures than those I planned. If my skin care professional discovers such other or different conditions, I will be referred to an appropriate medical care provider.

I also realize that the following risks and hazards may occur in connection with the particular procedure: worsening or unsatisfactory appearance, redness, swelling, scarring, and reoccurrence of the original condition.

If this procedure creates light sensitivity, I understand I must always use sunscreen SPF 25 or greater throughout the course of treatment.

I acknowledge my obligation to follow the written and or spoken instructions covering my pre and post treatment skin care regimen.

I understand that multiple treatments may be required for some services. If so, the cost of these treatments was disclosed prior to the first treatment.

I certify that I have read the above consent and fully understand it. I have been given ample opportunity for discussion and all of my questions have been answered to my satisfaction. I hereby consent to the procedure. This constitutes the full disclosure and supersedes any previous verbal or written disclosures.

Client's name (please print):_____

Client's signature:_____

Date:_____ Time:_____

INFORMED CONSENT – COVID-19 PANDEMIC

I, _____, understand that I am opting for a service that is not urgent and not medically necessary.

I also understand that the coronavirus disease (COVID-19) has been declared a worldwide pandemic by the World Health Organization. I further understand COVID-19 is extremely contagious. State and federal health agencies recommend social distancing.

I recognize that the staff at Legacy 41 are closely monitoring this situation and have put in place reasonable preventive measures targeted to reduce the spread of this virus. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 if I proceed with this elective service.

Accordingly, I acknowledge and assume the risk of becoming infected with COVID-19, and any variation or mutation thereof, through this elective service and I gave my express permission for the staff at Legacy 41 to proceed with the same. This consent applies to any follow up or additional services in the upcoming months.

I understand that even if I have been tested for COVID-19 and received a negative test result, the tests may not have detected the virus or I may have contracted COVID-19 after the test. I will not hold this business and professional offering the service responsible for any liability related to COVID-19 and any variation or mutation thereof.

I understand that exposure to COVID-19 before, during, or after my procedure(s) may result in complications and/or delayed healing.

I have been given the option to defer my service to a later date. However, I understand all the risks including those noted herein and I would like to proceed with this service. I have been offered a copy of this consent form.

I understand the explanation and consent to the procedure.

Client Signature: _____ Date: _____

Provider's Signature: _____Date: _____

Treatment Agreement:

I, the specialist, confirm that I have checked all paperwork including consent forms and medical history. I have discussed all procedure points with my client and he / she understands all of the elements of the treatment. Aftercare advice has been presented to the client.

Specialist's name: Reilly Shimko

Specialist's signature: _____

Date: _____

I, the client, agree with all points listed and discussed. I wish to proceed as recorded. I participated fully in the decision for the selected area or areas intended for my treatment. I hereby agree to follow after advice.

Client's name (please print): _____

Client's signature: _____

Date: _____

Recorded Documentation:

Name:	
Date:	Anesthetic used:
Treatment area(s):	Other treatments on this day:
Photographic evidence:	Fitzpatrick Scale number:
Tolerance level (1 lowest, 10 highest)	Were any other people present?

Notes: Comments made by the client and or to the client after the procedure and information relating to further treatments required:

To be completed by the client at the end of the procedure:

My procedure has been completed to my satisfaction and I have been given the opportunity to discuss any immediate concerns with my specialist. I fully understand my aftercare instructions and have my aftercare advice sheet.

Client signature: _____

Specialist's signature: _____

Date: _____

Subsequent Visit Form:

When was the client last here and what treatment(s) was performed? _____
_____

Were the client's expectations for the prior treatment(s) met? _____
_____

Did the treated area(s) heal as expected or described? _____
_____

What is the agreed upon objective for today's procedure(s)? _____
_____

What is the predicated outcome for today's procedure(s) and what are the recommendations?
_____
_____

Describe the treatment area(s) including a description of the appearance of the skin: _____
_____
_____

Has the client filled out the reconsent forms?_____

Has the specialist filled out a Treatment Plan for the treatment(s) being done today?_____

Date: _____

Client's name: _____

Client's signature: _____

Specialist's signature: _____