RIOS HEALTH & BEAUTY
ENHANCING BEAUTY, NOURISHING HEALTH

SCLEROTHERAPY
VARICOSE VEINS INJECTION WITH ASCLERA
CONSULTATION FORM

Name : _____ Date : _____

Date of birth : _____ Age : _____ ☐Male ☐Female ☐ Non-Binary

Address: _____

City: _____State : _____ Zip Code : _____

Phone:_____ Email : _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us?_____

Are you referred by someone? If so, whom?_____

Would you like to be added to our email list for news and exclusive offers? _____

MEDICAL HISTORY

Please mark any of the following conditions you may currently have

☐ High Blood Pressure
☐ Breastfeeding
☐ Bleeding Disorders
☐ Diabetes
☐ Frequent Headaches
☐ Thyroid
☐ Hepatitis
☐ Pregnancy
☐ Stroke
☐ Birth Control
☐ Seizures
☐ Cancer
☐ Lung Disease
☐ Illicit Drug User
☐ Heart Disease
☐ Other _____

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Any other conditions? _____

If you ticked any boxes, please give further details _____

_____

Do you have any allergies? ☐ Yes ☐ No

If so, please list all _____

List all medications you take, including vitamins, herbal supplements, aspirin, hormones, and topical

_____

_____

Are you currently pregnant or trying to get pregnant? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No

Have you ever had any hormone replacement therapy in the past? ☐ Yes ☐ No

If so, when was your last treatment? _____

Any likes or dislikes about past treatments? _____

_____

<u>By signing below, you agree to the following:</u>

I have completed this form truthfully and to the best of my knowledge. I agree to waive all liabilities toward my medical members and the employer for any injury or damages incurred due to any falsification of my medical history

_____ _____

Patient Name (Printed) **Patient Signature**

_____

Date

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SCLEROTHERAPY
VARICOSE VEINS INJECTION WITH ASCLERA
CANCELATION POLICY

To ensure the provision of high-quality care within a reasonable timeframe, we have implemented an appointment and cancellation policy.

As appointments are in high demand, canceling your appointment in advance allows us to offer the time slot to another individual seeking timely care. This policy helps us optimize our appointment availability for all clients.

During the appointment booking process, you will be required to make a $100 deposit, which will be applied as a credit towards your scheduled treatments.

We understand that circumstances may arise requiring you to cancel or reschedule your appointment. To avoid any inconvenience, please notify us at least 72 hours before your scheduled appointment. In such cases, your deposit will either be refunded or applied towards a future appointment. However, if you provide less than 72 hours notice, a $100 cancellation fee will be charged.

Please note that if you arrive more than 20 minutes late for your appointment, it will be considered a no-show, and the cancellation fee will be applied.

We are more than happy to address any inquiries or concerns you may have regarding our cancellation policy.

I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by its terms. I agree to pay the cancellation fee in the event of a missed appointment.

Patient Name (Printed)	Patient (signature)	Date

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PATIENT COUNSELING CONSENT FOR SCLEROTHERAPY WITH ASCLERA

ABOUT THIS FORM

This form is designed to provide you with the information you need to make an informed decision about whether to have Sclerotherapy performed today. If you have any questions or do not understand any potential risks, please do not hesitate to ask us.

WHAT IS SCLEROTHERAPY?

Asclera® (polidocanol) Injection is a prescription FDA-approved medicine that is used in a procedure called sclerotherapy to remove unwanted varicose and spider veins on your legs. It is administered by your healthcare provider.

Sclerotherapy (pronounced sklair-o-THAIR-uh-pee) is a medical procedure that has been used since the 1930s to treat varicose and spider veins. As the standard of care, it is Gold Standard therapy and is considered one of the most effective treatments for removing unwanted leg veins.

Today's procedure involves injecting Asclera directly into your vein(s), to seal, shut down, and fade over several weeks. The treated vein is then naturally resorbed by the body.

DOES SCLEROTHERAPY WORK FOR EVERYONE?

Individual results may vary depending on varicose vein severity, disease progression, skin tone, and number of treatments.

Most people treated will have good results, however, there is no guarantee that Sclerotherapy will be effective in every case.

In clinical studies, 88% of patients were satisfied or very satisfied with their Asclera treatment at 12 weeks.

HOW MANY TREATMENTS WILL I NEED?

The number of treatments differs from patient to patient, depending on the extent of spider veins present. One to six or more treatments may be needed; the average is three to four. You and your provider will discuss a treatment plan that addresses your needs.

WHAT ARE THE MOST COMMON SIDE EFFECTS?

• Bruising: Last from one to several weeks. The use of a support hose may be recommended and avoidance of alcohol and anticoagulant medication for 72 hours before each treatment session may minimize effect.

• Transient Hyperpigmentation: Approximately 30% of patients who undergo Sclerotherapy notice a discoloration of light brown streaks after treatment. In almost every patient, the veins become darker immediately after the procedure (but then go away.) In rare instances, this darkening of the vein may persist for four to twelve months.

• Pain: A few patients may experience mild pain at the site of the injection. The veins may be tender to the touch after treatment. This pain is usually temporary, in most cases lasting from 1-7 days at most.

• Blood accumulation in the treated vessel: This may present as a tender bump at a treatment site. The use of prescribed compression hosiery will minimize this possibility (especially when treating Reticular Veins.)

WHAT TO DO AFTER TREATMENT?

• Wear compression hose 15-20mmHg for 2-3 days continuously, and then for 2-3 weeks during the daytime

• Walk for 15-20 minutes daily

• For 2-3 days, avoid heavy exercise, sunbathing, long plane flights, hot tubs or sauna

Contraindications: Patients with significant coagulation, circulatory problems, insulin-dependent diabetes, or pregnant women should not undergo today's procedure.

I acknowledge that I have read and understand this consent form.

A copy has been provided by my healthcare provider.

I also acknowledge that I am not pregnant or breastfeeding and do not have any of the disease processes listed above.

_____ _____

Patient Name (please print) DATE:

_____ _____

Patient Signature DATE:

_____ _____

Provider Signature DATE:

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Patient Name (Printed)	Patient (signature)	Date

VARICOSE VEINS INJECTION WITH ASCLERA
PHOTO AND VIDEO RELEASE FORM

I, _____ hereby grant and authorize **RIOS HEALTH AND BEAUTY.** I grant the right to capture, modify, edit, reproduce, exhibit, publish, distribute, and utilize any photographs, videos, and/or audio recordings taken of me for lawful promotional purposes. These materials may include but are not limited to, newspapers, flyers, posters, brochures, advertisements, press kits, websites, social media platforms, and other forms of print and digital communication. I provide this authorization without expecting any payment or other forms of consideration.

This authorization remains in effect indefinitely and applies to all languages, media, formats, and markets, whether currently known or discovered in the future.

I willingly waive any rights to royalties or other compensation arising from or related to the use of these photographs or recordings.

I acknowledge and accept that the materials created through this agreement will be the property of **RIOS HEALTH AND BEAUTY** and will not be returned to me.

I hereby release and discharge **RIOS HEALTH AND BEAUTY.** from any liability, claims, or legal actions that may arise, including those made by myself, my heirs, representatives, executors, administrators, or any other individuals acting on my behalf or on behalf of my estate.

By signing below, I confirm that I have thoroughly read and comprehended the entirety of the release agreement stated above.

By signing below, I hereby acknowledge that I have completely read and fully understand the above release agreement

_____	_____	_____
Patient Name (Printed)	Patient (signature)	Date