



BOTOX/DYSPOORT 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.

- | | | |
|---|---|---|
| <input type="checkbox"/> Alopecia | <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Recent Permanent Make Up |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Recent Surgery |
| <input type="checkbox"/> Fillers/ Botox | <input type="checkbox"/> Sunburn | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Ultra-Sensitive Skin | <input type="checkbox"/> Use of Alpha, Hydroxy Acid |
| <input type="checkbox"/> Eczema/Rashes | <input type="checkbox"/> Recent Chemical Peel | <input type="checkbox"/> Use of Accutane, Renova or Retin-A |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Recent Scar Tissue | |

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 taking blood thinning medication? ☐ No ☐ Yes

If yes, please explain:

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

If yes, please explain:

Do you have any implants? ☐ No ☐ Yes

If yes, please explain:

Have you had any Botox/ Dermal Filler treatments recently? ☐ No ☐ Yes

If yes, please state when & explain:

Have you had any adverse reactions to any previous treatment ☐ No ☐ Yes

If yes, please explain:

Have you exfoliated or applied any products to your face in the last 24 hours? ☐ No ☐ Yes

If yes, please state which products:

Have you had any allergic reactions to any of the following?

☐ Aspirin

☐ Botox/Dysport

☐ Hydrocortisone

☐ Lidocaine (Anesthetic)

☐ Collagen

☐ Egg



Cosmetic Treatments or Surgery History

☐ Dermal Fillers ☐ Botox/Dysport ☐ Others _____

By signing below, you agree to the following:

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



BOTOX/DYSPORT

"Botox" is one of the most familiar brands of botulinum toxin injections. Botulinum toxins are neurotoxins that impact nerves, leading to muscle weakening. These injections serve both cosmetic and medical purposes. Practitioners administer small quantities of botulinum toxin into specific areas to reduce wrinkles, prevent migraines, and manage a broad spectrum of other health conditions.

Botox works by blocking nerve signals to muscles, resulting in the temporary inability of the injected muscles to contract. This effect typically lasts for about three to four months. The specific muscles that are injected depend on the areas of concern, and it's possible to treat multiple areas during a single session.

RISK & COMPLICATIONS

For every treatment, there are inherent risks involved. It is crucial that you thoroughly comprehend these risks before proceeding with the treatment. While providing a complete medical history can help reduce these risks, there may still be unforeseen complications that may arise. If you have any concerns about these risks, do not hesitate to reach out to your healthcare professional.

The potential risks and complications include

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergic reaction | <input type="checkbox"/> Skin irritation | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Infection | <input type="checkbox"/> Scarring of the skin | <input type="checkbox"/> Anaphylaxis |
| <input type="checkbox"/> Eye Dryness or Tearing | <input type="checkbox"/> Increased sensitivity | <input type="checkbox"/> Arterial occlusion |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Headaches | |

It's essential to consult with a qualified healthcare provider to address any concerns and assess your individual risk factors before undergoing any treatment.

In rare cases, botulinum toxin may extend beyond the intended treatment area, resulting in botulinum-like signs and symptoms. These may include breathing difficulties, trouble swallowing, muscle weakness, and slurred speech. If you experience any of these unusual symptoms following treatment, it is imperative to seek immediate medical attention.



BOTOX/DYSPORT PATIENT CONSENT FORM

Please initial each statement:

- _____ During the treatment, despite all precautionary measures taken by the technician, it's important to recognize that there is a possibility of injury. I will not hold the technician responsible for any issues that may arise as a result of undergoing the procedure.
- _____ I understand that there are inherent risks associated with botulinum toxin/Botox. If I experience any form of adverse reaction, I will promptly seek medical attention and inform my technician.
- _____ It is my responsibility to communicate any concerns I may have to the technician before the procedure.
- _____ I understand and agree to follow the aftercare instructions provided by my technician. I am aware that not adhering to the aftercare instructions may impact the achievement of the desired results.
- _____ I acknowledge that the product will be injected into the muscles of my face as part of the botulinum/Botox process. The technician performing the procedure will not be held liable for any damages to my skin or me for any reason, especially if I fail to follow aftercare instructions.
- _____ I have disclosed all pertinent medical history, and I commit to informing my technician of any changes that may occur in the future.



By signing below, I hereby acknowledge that I have read and understand all the information in this informed consent agreement. I understand that this agreement is legal and binding and will remain in effect for this procedure and all future follow-ups conducted by RIOS HEALTH AND BEAUTY, and any of their associates. I fully understand the risks and side effects associated with the treatment. I freely assume these risks and release RIOS HEALTH AND BEAUTY, and any of their associates of all liability.

Patient Name (Printed)

Patient Signature

Date





BOTOX/DYSPOORT PATIENT TREATMENTS RECORD

Name : _____ Date : _____

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

Address: _____

City: _____ State : _____ Zip Code : _____

Phone: _____ Email : _____



Botox /Dysport

Neurotoxin Type	
Lot #	
Expiration	
Neurotoxin Type	
Lot #	
Expiration	
Neurotoxin Type	
Lot #	
Expiration	



BOTOX/DYSPO PATIENT TREATMENTS RECORD

Name : _____ Date : _____

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

Address: _____

City: _____ State : _____ Zip Code : _____

Phone: _____ Email : _____

DATE	AREA TREATED	DOSE	TREATMENT NOTES	PRICE



BOTOX/DYSPORT 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



BOTOX/DYSPO 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 \$50 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 cancellation fee will be charged.

Please note that if you arrive more than 15 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



Post-Care Instructions for Botox

1. **Do NOT massage or apply pressure on the treated area for 6-8 hours** after treatment since Botox may migrate to areas of undesirable effectiveness.
2. **Do NOT lie down for 6 hours after treatment. Also Do NOT lean forward, shower, or cook over a hot stove.**
3. **You MUST keep your head UPRIGHT for at least 6 hrs after injection.**
4. **Avoid yoga or other rigorous exercise activities, extensive sun or heat exposure, and alcoholic beverages for the 1st 24 hours after treatment.** This may cause temporary redness, swelling, and itching at the injection sites.
5. **Avoid facials and saunas for 24 hours after treatment** since this will decrease the chance of your blood pressure rising and thus decrease the chance of minor and temporary bruising.
6. **Try to exercise your treated muscles for about 2 hours after treatment** (e.g. practice frowning, raising your eyebrows, or squinting). This helps to work Botox Cosmetic® into your muscles. It will NOT negatively impact your treatment if you don't do this.
7. **Headaches are common.** Botox is even used to treat headaches. However, if you have a headache we recommend you avoid aspirin or aspirin-containing products. You may opt instead to use Motrin, Tylenol, and/or cool compresses. If headaches continue or worsen, contact your physician.



8. Avoid taking Advil, Vitamin E, Ginger, Ginko, Bilboa, Ginseng, and Garlic for 2 weeks since this may increase the risk of bruising. You may shower and do most other regular daily activities.

9. Note that any bumps or marks will go away within a few hours. If you do develop a bruise it will resolve like other bruises you have had in about a week. There is occasionally some mild pain, swelling, itching, or redness at the site of injection similar to most other injections. Redness may last for 1-2 days, rarely longer. You may apply cold compresses or acetaminophen (Tylenol) to reduce swelling or discomfort.

10. Results of your treatment may take up to 14 days to take full effect although many people will recognize the benefits in 3-5 days after treatment.

11. Botox Cosmetic® is a temporary procedure. In most people the benefits of Botox last about 6 months. Sometimes a few wrinkles may start to return in 2-3 months. The effectiveness of Botox will last longer with successive treatments.

12. Initially, the physician may want to see the patient between 2-4 weeks for a brief “touch-up” and checkup of the procedure. If you allow Botox Cosmetic® to completely wear off, it is difficult for the doctor to see how your muscles reacted and therefore optimal results for your face can be more difficult to achieve.

13. Makeup: It is recommended that you wait 12 hours after the treatment before applying make-up.

14. Cold compresses may be used 10 minutes on and 10 minutes off to reduce swelling 2-3x per day during the 1st 1-2 days if needed