IVita Wellness, LLC

Botox & Filler Consent

Name: _____ Phone number:_____

Email: _____

Address: _____

DOB: _____

Primary Care Physician: _____

Primary Care Physician phone number: _____

Allergies Drug & Non-drug (vitamins) or food or environmental:_____

Past Medical History: _____

Medications taking or prescribed: _____

Vitamins taking or over the counter: _____

Medical History

Diabetes: yes or no

Hepatitis: yes or no

Herpes Simplex: yes or no

Menopause: yes or no

Irregular Menses: yes or no

Heart problems: yes or no

Hysterectomy: yes or no

High Blood pressure: yes or no

Sensitivity to Anesthetic: yes or no

Lupus or any autoimmune disorder: yes or no

Myasthenia gravis/multiple sclerosis or any neuromuscular disorder: yes or no

Light sensitivity: yes or no

If yes, please explain

Active infections bacterial/viral/fungal -for example (active acne, cold sores)	Yes	No	_____
On anticoagulants -for example (NSAIDS,ASA,Coumadin/Warfarin)	Yes	No	_____
Keloids	Yes	No	_____
Immunocompromised	Yes	No	_____
Hives/Rashes/Warts	Yes	No	_____
Skin Cancer	Yes	No	_____
Pregnant/Breastfeeding	Yes	No	_____
Waxing	Yes	No	_____
Electrolysis	Yes	No	_____
Diabetes	Yes	No	_____
Hypersensitivity to skin products	Yes	No	_____
Rosacea	Yes	No	_____
Skin-related autoimmune disorders	Yes	No	_____
Actinic (solar) Keratosis	Yes	No	_____
Tanning within the last 6 weeks	Yes	No	_____
Use of acne products/drugs	Yes	No	_____
Laser skin resurfacing	Yes	No	_____
Chemical Peels	Yes	No	_____
Laser work of any type	Yes	No	_____

Areas of interest for botox or filler?_____

I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.

Patient name printed: _____ Date:_____

Patient name signature :_____

INFORMED CONSENT FOR BOTULINUM TOXIN INJECTION

FOR THE TEMPORARY TREATMENT OF SUPERFICIAL FACIAL WRINKLES. Please initial after each statement and sign at the bottom.

Botox® is the botulinum toxin and works by paralyzing nerves and muscles.

1)I consent to and authorize _____ to perform a treatment of facial wrinkles with Botox.

2)The nature and purpose of the treatment has been explained to me and questions I have regarding the treatment have been answered to my satisfaction._____

3)I understand surgery or other treatment alternatives may be as effective or more effective in reducing the appearance of wrinkles._____

4) I am fully aware of the risks of complications or injuries that can occur from this treatment, both from known and unknown causes, and I freely assume those risks._____

The known complications could include:

-Redness, swelling/edema,itching,pain or pressure lasting more than one week
-Nodules or induration at the injection site
-Discoloration of the injection site
-Poor effect
-Allergic reactions
-Discoloration of the injection site
-Poor effect
-Allergic reactions

- The effects of Botox are apparent 2-5 days after treatment but can take full 2
weeks to see the final result
-The effects usually last 4-6 months. Periodic retreatment will be necessary to
maintain the effects of botox
-Repeated treatment may lead to permanent loss of muscle tone in the treated
area
-Bruising
- Facial asymmetry
-Paralysis leading to droopy eyelid and double vision
-Some patients may experience weakness or flu-like symptoms
-Visual problems
-Dry eyes
- Some patients may develop antibodies to botox

5) I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophic scars, a history of any autoimmune disease, or immunotherapy. I am not pregnant, breast-feeding, and I have no known allergy to Botox®/Dysport®._____

6) I certify that I have read this entire informed consent and that I understand and agree to the information stated in this form. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian will also be required before treatment. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns. I agree that any picture taken of my treatment site may be used for publication and teaching purposes, however, my name will not be disclosed and complete confidentiality of my name will be maintained._____

7) No guarantee, warranty or assurance has been made as to the treatment results_____

8) I will hold IVita Wellness,LLC, it's owner[s], agents, employees and shareholders completely harmless from all and any litigation or claims made should I have any adverse reaction to Botox® or reaction to Botox®. Any and all complications should be seen in the emergency room or by your local physician. Any subsequent care or corrections would be at your own cost and without compensation from IVita Wellness,LLC. IVita

Wellness, LLC reserves the right, under all circumstances and without penalty, to not perform the procedure should the decision be made by them.

If you are planning a LASIK® procedure, please inform the instructor as your Botox® may be deferred.

I understand that the results are of temporary nature, and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions described here including: _____

No laying down or reclining for four hours after injection

No scratching or running the injected area

No bending forward for four hours

Makeup should be avoided for 1-2 hours after injection

This agreement is non-transferable and may not be altered by anyone without the express written consent of IVita Wellness,LLC. Further, this agreement does not expire.

Patient name printed: _____ Date:_____

Patient name signature :_____

INFORMED CONSENT FOR TREATMENT WITH INJECTABLE FILLERS

My signature and initials after each statement below constitutes my acknowledgment that:

I,_____ consent to and authorize _____ to perform with injectable fillers to improve the appearance of scars and/or wrinkles, or to have my lips augmented (made larger). The fillers to be used include Hylaform, Restylane, Collagen, and/or Juvederm._____

The area to be treated _____

The filler being used _____

The nature and purpose of the treatment has been explained to me and questions I have regarding the treatment have been answered to my satisfaction._____

I am fully aware of the risks of complications or injuries that can occur from this treatment, both from known and unknown causes and I freely assume those risks._____

The known complications could include:

-Redness, swelling/edema, itching, pain or pressure lasting more than one week
-Nodules or induration at the injection site
-Discoloration of the injection site
-Poor effect or weak filling
-Allergic reactions
-In extremely rare cases, skin necrosis or “death of skin” may occur as a result of injection into a blood vessel. This may result in financial costs, extended care and scar formation.

I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophic scars, a history of any autoimmune disease, Vascular disease, HIV disease, immunotherapy or psychiatric disease.. I am not pregnant, breast-feeding, and I have no known allergy to Hyaluronic acid, anesthetic agents, latex gloves [should they be used] or bovine source collagen._____

I certify that I have read this entire informed consent and that I understand and agree to the information stated in this form. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian will also be required before treatment. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns. I agree that any picture taken of my treatment site may be used for publication and teaching purposes, however, my name will not be disclosed and all reasonable attempts to maintain complete confidentiality of my name will be maintained. IVita Wellness, LLC staff maintain the right not to treat minors even with adult consent

Furthermore, I completely and totally indemnify IVita Wellness,LLC, its owner[s], agents, employees, shareholders and [independent] contractor's from any and all liability in relation to the performance of this procedure[s]

No guarantee, warranty or assurance HAVE been made as to the treatment results_____

I understand that the results are of temporary nature, and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions described here including:_____

Avoiding prolonged sun or UV exposure

Avoiding saunas for two weeks after injection

Avoiding steam baths for two weeks after injection

Makeup should be avoided for least 12 hours after injection

IVita Wellness,LLC maintains the right to defer treatment on any client should it be in either of their opinion's that any treatment or further treatment is not warranted.

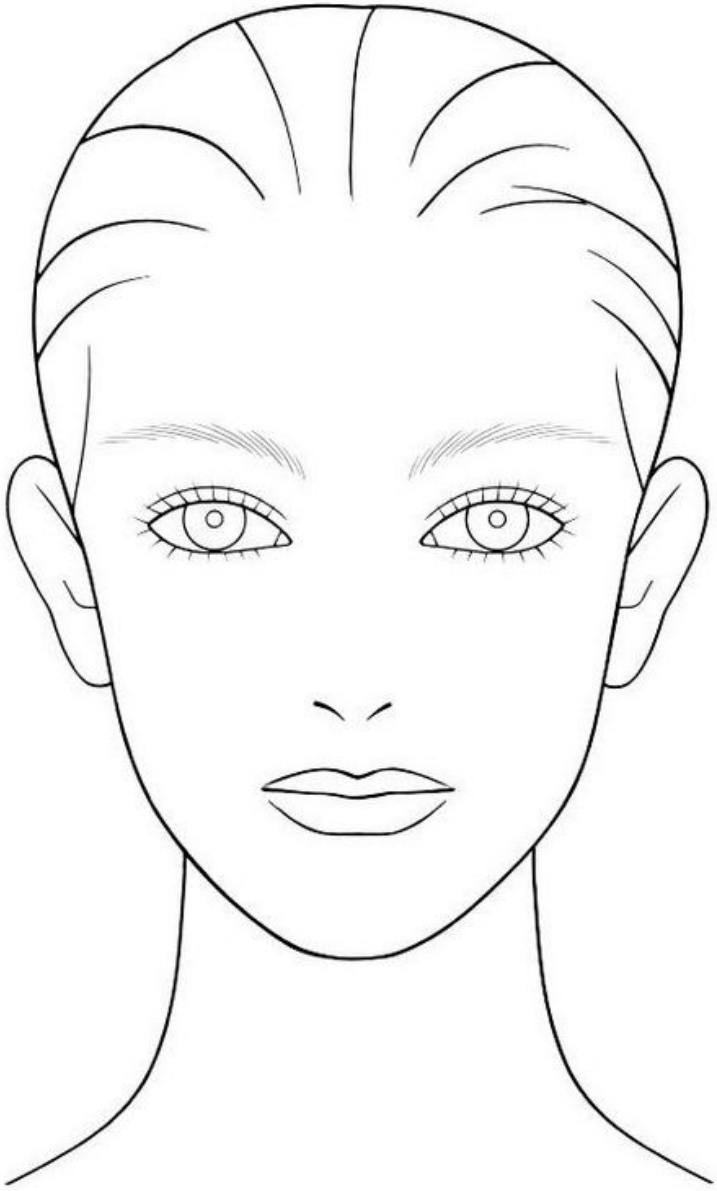
This agreement is binding. It may not be modified by the person receiving the injections or by anyone else without the express written approval by IVita Wellness,LLC that any modifications are allowed. This agreement does not expire.

Patient name (please print)_____

Patient signature_____

Date:_____

Treatment Chart For Botox and FIller Injection Pattern
(FOR PROVIDER USE)



BOTOX/UNITS USED

Frown lines (between the eyes) ___
Horizontal (forehead lines) ___
Crows Feet (next to eyes)___
Bunny lines (bridge of nose)___
Droopy eyebrow___
Lip Flip (above lip)___

Total areas treated _____

Total units used_____

Lot number/expiration_____

FILLER USED

Lip Augmentation ___
Nasolabial Folds ___
Marionette Lines___
Vertical Lip Lines___
Scar Fill-In___

Total areas treated _____

Amount of filler used_____

Lot number/expiration_____

Patient name printed: _____ Date:_____

Patient name signature :_____

Provider name printed:_____ Date:_____

Provider name signature:_____