Timeless Rx
...turning back the hands of time

SKIN CARE QUESTIONAIRE

Name:_____Date:_____
Address:_____Age:_____
_____Date of birth: _____

Home Phone:_____
CellPhone_____ Cell Phone Carrier: _____
Email :_____@_____
Emergency contact & Phone #: _____

How were you referred to us?: _____

What areas/ topics will we discuss today?
O BASIC SKIN CARE What Skin Line are you currently using ?_____
O SPECIFIC FOCUS (circle as needed)

FACE	Wrinkles	NECK	Wrinkles	BODY	Wrinkles
	Texture		Texture		Texture
	Color		Color		Color
	Looseness		Looseness		Looseness
	Hair		Hair		Hair

Acne _____ Infection _____Rosacea _____ Sun Spots/Damage_____

When you go out in the sun do you ?
_____Always Burn _____Usually Burn _____Sometimes Burn
_____Rarely Burn _____Very Rarely Burn _____Never Burn

Have you ever had treatments with?: (date)		Date of most recent application
Botox	Y / N	_____
Restylane /Juvederm	Y / N	_____
Collagen	Y / N	_____
Hylaform	Y / N	_____
Radiesse	Y / N	_____
Other _____		_____

Medical History (check which apply)

- High blood pressure
- Bleeding tendencies
- Heart disease
- Diabetes
- Migraines
- Arthiritis
- Fever blisters/cold sores
- Neurologic disease

Surgical history (check which apply)

- Eyelids
- Brow lift
- Midface lift
- Facial implants
- Face lift
- Neck lift
- Liposuction of face/neck
- Lip augmentation

Are you pregnant or nursing? Y / N
Do you hav any active infections? Y / N
Do you smoke cigarettes? Y / N
Do you develop fever blisters/cold sores? Y / N
Do you take aspirin, ibuprofen, or blood thinners? Y / N
Do you have any medical allergies? Y / N
If so, ist please:_____

Please list any medications you take regularly: _____
_____

I also give Timeless Rx my permission to photograph treatment areas for medical purposes. These images may be viewed, shared or previewed for various events.

Signed_____

Thank you.
The information you have provided is essential in our comprehensive evaluation of your goals.

Timeless Rx 1970 N. Hwy 190 Suite B, Covington , La 70433 985-893-6073

Updated 4/8/16

Timeless Rx
...turning back the hands of time

Botox/Dysport/Kybella Consent Form

Please initial each section to indicate that you understand each topic. Do not initial if you desire more information.

Proposed Treatment Injection of a very small amount of Dysport/Botox®/Kybella cosmetic, a purified protein derivative, into a specific muscle, the result is weakness or relaxation of the muscle and improvement of the lines or wrinkles that the muscle action has formed. **Initials:** _____

Anticipated Benefit Response is usually seen 3-10 days after the injection. Typically, the muscle action (and wrinkles) will return in 3-5 months. At this point, a repeat treatment will relax the muscle and soften the lines again.

I understand that several sessions may be needed to complete the injection series. I understand that there is a separate charge for any subsequent treatment. Typically, an evaluation (and touch up) is scheduled 2 weeks after the initial appointment. **Initials:** _____

Risks and Complications Possible side effects include: transient headache, swelling, bruising, pain at injection site, twitching, itching, numbness, asymmetry (unevenness), temporary dropping of the eyelids or eyebrows, respiratory problems, and allergic reaction, flu like symptoms with mild fever, back pain, weakness of adjacent muscles, reduced eyelid blinking. These side effects are rare, but have been reported. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual. Known significant risks have been disclosed, yet the theoretical risk of unknown complications does exist.

*Cold compress may be applied to treatment sites to reduce swelling and bruising. Vitamin K cream is also recommended to treat bruising.

Bruising may occur after Dysport/Botox®/Kybella injections. Substances that increase the risk of bruising include herbal medications, Vitamin E, aspirin, Motrin, Coumadin, other non- steroidal anti-inflammatory drugs and blood thinners. I understand that if I have taken any of the above within the past 7 days, I have an increased risk of bruising. I understand that if I am taking a blood thinning medication, this treatment may result in significant bruising and may not be recommended. **Initials:** _____

I attest that I have provided my physician with a list of **all** my current medications and supplements. **Initials:** _____

I understand that there may be a higher possibility of side effects if I do not follow certain instructions. I will adhere to these instructions for at least 4 hours from the time of treatment. These include not laying down or bending forward for extended periods of time for at least 4 hours from the time of treatment and not manipulating or massaging the treated area for at least 4 hours after. Avoid strenuous exercise and yoga after the procedure; which can raise blood pressure, causing more bruising and swelling. **Initials:** _____

Pregnancy & Neurological Disease I understand that there are certain conditions where Dysport/Botox®/Kybella treatments are not recommended. These include: Neurological diseases, such as myasthenia gravis, Eaton-Lambert syndrome, Lou Gehrig's disease, Pregnancy or breastfeedingNone of the above conditions apply to me. **Initials:** _____

Limitations and Alternatives Dysport/Botox®/Kybella is best at treating dynamic facial lines, those caused by facial muscle activity; lines present at rest may or may not improve. A treatment may be effective for variable lengths of time with subsequent treatments, may not work as well or for as long as expected, or may not work at all. I have been informed of other alternatives which exist for the treatment of wrinkles such as topical creams, chemical peels, laser treatments, surgical removal of the frown muscles, forehead/brow lift, facelift, collagen or hyaluronic acid treatments. **Initials:** _____

Cost/Fees Payment for this cosmetic procedure is my responsibility. I understand that there will be an additional fee for touch ups. Because Dysport/Botox®/Kybella therapy for wrinkles is considered a cosmetic procedure, insurance does not pay for treatment. Payment at the time of service is requested for all patients. We request a 48-hour notice of cancellation for all scheduled Botox® appointments. If less than 48 hours notice is given, charges may incur. **Initials:**

_____

I understand that the practice of medicine and surgery is not an exact science and that no results are guaranteed, including Dysport/Botox®/Kybella therapy for wrinkles and lines. **Initials:**

_____

I have read the above and understand it. The doctor and/or doctor's associates have answered my questions satisfactorily. I accept the risks and complications of the procedure. I hereby give consent to perform this and all subsequent Botox treatments with the above understood. I hereby release the doctor, the person injecting the Botox and the facility form liability associated with this procedure.

_____

Patient Name (Print) Date

_____

Patient Signature Date

_____

Witness Signature Date

Timeless Rx
...turning back the hands of time

Dermal Filler Treatment Consent Form

A. Purpose and Background

As a client of TIMELESS RX, you have requested administration of a Dermal Filler, a stabilized hyaluronic acid used in the correction of moderate to severe facial wrinkles and folds. All medical and cosmetic procedures carry risks and may cause complications. The purpose of this document is to make you aware of the nature of the procedure and its risks in advance so that you can decide whether or not to go forward with the procedure. (Note: "Dermal Filler" is used in this form to refer to Juvederm Ultra or Ultra Plus, Perlane, Restylane, Restylane Silk, Radiesse, Voluma and any other similar products.)

B. Procedure

1. This product is administered via a syringe, or injection, into the areas of the face sought to be filled with the hyaluronic acid to eliminate or reduce the wrinkles and folds.

2. An anesthesia, numbing medicine can be used to reduce the discomfort of the injection.

3. The treatment site(s) is washed first with an antiseptic (cleansing) solution.

4. Dermal Fillers are a clear transparent gel that is injected under your skin into the tissue of your face using a thin gauge (30G) needle.

5. The depth of the injection(s) will depend on the depth of the wrinkle(s) and its location(s).

6. Multiple injections might be made depending on the site, depth of the wrinkle and technique used.

7. Following each injection, your injector will gently massage the correction site to conform to the contour of the surrounding tissues.

8. If the treated area is swollen directly after the injection, ice may be applied on the site for a short period of time.

9. After the first treatment, additional treatments of Dermal Fillers may be necessary to achieve the desired level of correction.

10. Periodic touch-up injections help sustain the desired level of correction.

C. **Risks/Discomfort**

1. Although a very thin needle is used, common injection-related reactions could occur. These could include: some initial swelling, pain, itching, discoloration, bruising or tenderness at the injection site. You could experience increased bruising or bleeding at the injection site if you are using substances that reduce blood clotting such as aspirin or other non-steroidal anti-inflammatory drugs such as Advil.

2. These reactions generally lessen or disappear within a few days but may last for a week or longer.

3. As with all injections, this procedure carries the risks of infection. The syringe is sterile and standard precautions associated with injectable materials have been taken.

4. Some visible lumps may occur temporarily following the injection.

5. Some patients may experience additional swelling or tenderness at the injection site and in rare occasions, pustules might form. These reactions might last for as long as approximately 2 weeks, and in appropriate cases may need to be treated with oral cortisteroids or other therapy.

6. Dermal Fillers should not be used in patients who have experienced this hypersensitivity, those with severe allergies, and should not be used in areas with active inflammation or infections (ex: cysts, pimples, rashes or hives).

7. Dermal Fillers should not be used in areas other than the tissues of the face.

8. If you are considering laser treatment, chemical skin peeling or any other procedure based on a skin response after a Dermal Filler treatment, or you have recently had such treatments and the skin has not yet healed completely, there is a possible risk of an inflammatory reaction at the implant site.

9. Most clients are pleased with the results of Dermal Filler use. However, like any cosmetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatments to achieve the results you seek. While the effects of a Dermal Filler use can last longer than other comparable treatments, the procedure is still temporary. Additional treatments will be required periodically, generally within 6 months to one year, involving additional injections for the effect to continue.

10. After treatment, you should minimize exposure of the treated area to excessive sun or UV lamp exposure and extreme cold weather until any initial swelling or redness has gone away.

D. Benefits of Dermal Fillers

Benefits have been shown to be safe and effective when compared to Collagen skin implants and related products to fill in wrinkles, lines and folds in the skin on the face. Its effect, once the optimal location and pattern of cosmetic use is established, can last 6 months or longer without the need for re- administration.

E. Alternatives

This is strictly a voluntary cosmetic procedure. No treatment is necessary or required. Other alternative treatments which vary in sensitivity, effect and duration include: animal-derived collagen filler products, dermal fillers derived from the patient's own fat tissues, synthetic plastic permanent implants, or bacterial toxins that can paralyze muscles that cause some wrinkles.

F. Cost/Payment

The cost of treatment will be the patient's responsibility. Insurance does not cover cosmetic procedures.

G. Questions

This procedure has been explained to me by the staff of TIMELESS RX. If you have any questions about the product or procedure call the office or ask your practitioner prior to the service.

H. Consent

Your consent and authorization for this procedure is strictly voluntary. By signing this informed consent form, you hereby grant authority to TIMELESS RX AND REBA WEYMOUTH FNP-C, to perform facial augmentation and filler

therapy/injection using Dermal Fillers and/or administer any related treatment as may be deemed necessary or advisable in the diagnosis and treatment of your condition. The nature and purpose of this procedure, with possible alternative methods of treatment as well as complications, have been fully explained to your satisfaction. No guarantee has been given by anyone as to the results that may be obtained by this treatment. I have read this informed consent and certify that I understand its contents in full. I have had enough time to consider the information from my physician and feel that I am sufficiently advised to consent to this procedure. I hereby give my consent to this procedure and have been asked to sign this form after my discussion with TIMELESS RX AND REBA WEYMOUTH FNP-C.

Patient Name (Print) Date

Patient Signature Date

Witness Signature Date