

PATIENT INFORMATION AND MEDICAL HISTORY

Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ E-mail Address _____
 Date of Birth _____ Age _____ Sex _____

HISTORY

Please check if you have or have had –

Diabetes _____	Irregular menses _____
Hepatitis _____	Heart problems _____
Herpes _____	Hysterectomy _____
Menopause _____	Hypertension _____
Sensitive to anesthetic _____	Photosensitive Disorder _____
Lupus _____	Autoimmune illness _____

Are you under the care of a physician? _____

Current/Recent medications _____

IF YES, EXPLAIN

Keloid scars	Yes	No	_____
Hives	Yes	No	_____
Skin Cancer	Yes	No	_____
Waxing	Yes	No	_____
Electrolysis	Yes	No	_____
Cold Sores	Yes	No	_____
Hypersensitivity to skin products	Yes	No	_____
Skin Infections	Yes	No	_____
Tanning within the last 6 wks	Yes	No	_____
Use of acne products/drugs	Yes	No	_____
Laser skin resurfacing	Yes	No	_____
Chemical Peels	Yes	No	_____
Photo sensitizing substances	Yes	No	_____
Laser work of any type	Yes	No	_____

Medical Illness _____

Are you pregnant? _____

Allergies of any kind including drugs _____

Areas of interest for aesthetic treatment _____

Requested Area of Treatment:

BOTOX

Filler

Frown lines (between the eyes) _____
 Horizontal forehead lines _____
 Crow's Feet _____
 Bunny lines (bridge of nose) _____
 Droopy Eyebrow _____

Lip Augmentation _____
 Nasolabial folds _____
 Marionette Lines _____
 Vertical lip lines _____
 Scar fill-in _____

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

Patient Signature _____ Date _____

INFORMED CONSENT FOR BOTULINUM TOXIN INJECTION (BOTULINUM TOXIN TYPE-A AS BOTOX® FROM ALLERGAN) between the volunteer and Aesthetic medical Educators Training, Inc [“AMET”]

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, [REDACTED], consent to and authorize _____ to perform a treatment of facial wrinkles with Botox. [REDACTED]
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. [REDACTED]
3. I understand surgery or other treatment alternatives may be as effective or more effective in reducing the appearance of wrinkles. [REDACTED]
4. I am fully aware of the risks of complications or injuries that can occur from this treatment, both from know and unknown causes, and I freely assume those risks. [REDACTED]

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
 - The effects of Botox are apparent 2-5 days after treatment
 - 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 hypertrophy scars, a history of any autoimmune disease, or immune therapy. I am not pregnant, breast-feeding, and I have no known allergy to Botox®/Dysport®. [REDACTED]
 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. [REDACTED]

7. No guarantee, warranty or assurance has been made as to the treatment results [redacted]
8. I will hold AMET, its 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®. Further, I hold all instructors completely harmless from any and all litigation, malpractice suits or claims made in relation to my receiving Botox®. I further understand that this is a teaching class and as such the students who are injecting me are new and inexperienced with this product. Any and all complications should be seen in the emergency room or by your local physician. No clinical follow-up is provided by these students, instructors or AMET. Any subsequent care or corrections would be at your own cost and without compensation from AMET, the instructors or the students. AMET and its instructors have the right to limit the amount of Botox® someone will be given in the session, as once again, these are teaching sessions and are not meant to replace or substitute any private aesthetic procedure or consultation. AMET and its instructors maintain the right, under all circumstances and without penalty, to not perform the procedure should the decision be made by them.
9. If you are planning a LASIK® procedure, please inform the instructor as your Botox® may be deferred.

10. 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: [redacted]

- No laying down or reclining for four hours after injection
- No scratching or rubbing the injected area
- No bending forward for four hours
- Make up should be avoided for one to two hours after injection

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

11. I agree to pay _____ for the above mentioned services. _____

Patient Name (please print) [redacted]

Signature [redacted] Date [redacted]

Witness Signature _____ Date _____

INFORMED CONSENT FOR TREATMENT WITH INJECTABLE FILLERS BETWEEN THE VOLUNTEER AND AESTHETIC MEDICAL EDUCATORS TRAINING, INC (AMET)

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

12. 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 to be used _____
13. 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. _____
14. 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.
15. I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophy scars, a history of any autoimmune disease, Vascular disease, HIV disease, immune therapy 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. _____
16. 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. AMET instructors maintain the right not to treat minors even with adult consent
17. Furthermore, I completely and totally indemnify AMET, its owner[s], agents, employees, shareholders and [independent] contractor’s from any and all liability in relation to the performance of this procedure[s]. I also completely and totally indemnify all instructors associated with AMET from any and all liability in relation to the performance and consequence of this procedure[s]. I further understand that this is a teaching program, and the person’s injecting me have little to no experience in using these products. I also understand that there is no period of follow-up after this procedure is completed. There is no continuity of care after this procedure. This is inherent to the nature of a seminar teaching program. Any clinical follow-up and or corrections would have to be done at my own

cost with the practioner of my own choosing. AMET cannot recommend such practioners. Any and all concerns should first be seen in the local emergency room.

18. No guarantee, warranty or assurance HAVE been made as to the treatment results [redacted]

19. 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: [redacted]

- Avoiding prolonged sun or UV exposure
- Avoiding saunas for two weeks after injection
- Avoiding steam baths for two weeks after injection
- Make up should be avoided for at least 12 hours after injection

AMET's instructors and or course directors maintain the right to defer treatment on any volunteer 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 AMET that any modifications are allowed. This agreement does not expire.

20. I agree to pay _____ for the above mentioned services. _____

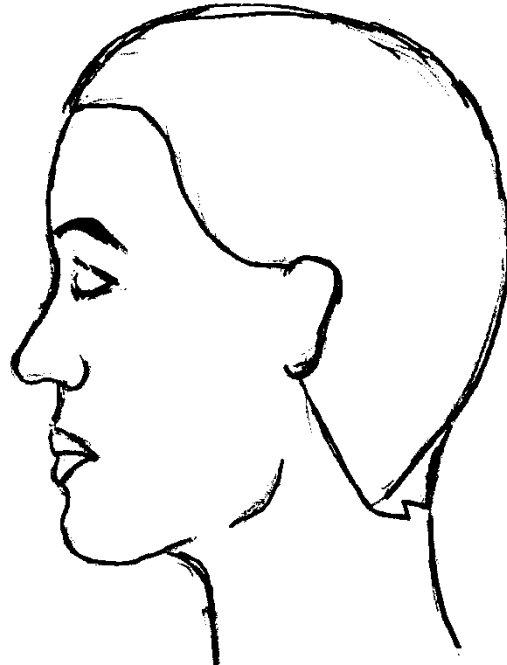
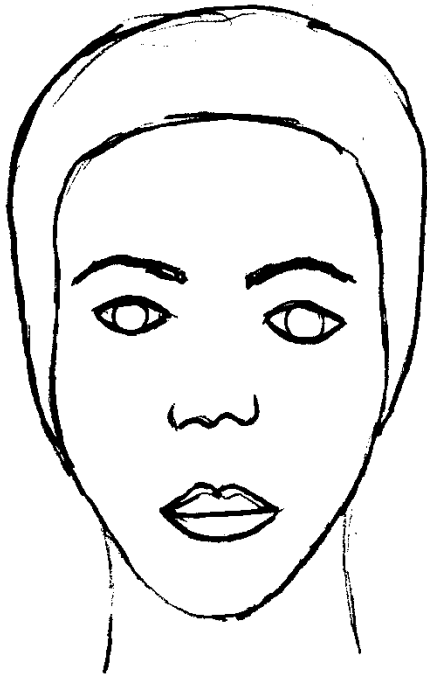
Patient Name (please print) [redacted]

Signature [redacted] Date [redacted]

Witness Signature _____ Date _____

Patient Treatment Chart for Botox & Filler

Injection pattern



Date

BOTOX

FILLER

Areas Treated	Units Used
1. Glabellar	_____
2. Frontalis	_____
3. Crows Feet	_____
4. _____	_____

Areas Treated	Amount Used
1. Lips	_____
2. Nasolabial	_____
3. Oral Commissures	_____
4. _____	_____

Total Areas Treated: _____

Total Units Used: _____

Total Amount Used _____

BOTOX Lot No. _____

Patient Signature

Provider Signature _____

MODEL PAYMENT FORM

NAME _____

DATE _____

<u>ITEM</u>	<u>FEE</u>	<u>QTY</u>	<u>TOTAL</u>
BOTOX	\$7/UNIT	_____	_____
Filler	\$250/SYRINGE	_____	_____
		_____	_____
SUBTOTAL			_____
Less:	Deposit		()
	Model Discount Card (Please Itemize)		()
Add:	Processing Fee		_____
Grand Total			=====

Method of Payment

- Cash
- Check payable to Aesthetic Medical Educators Training enclosed
- Charge to: _____Mastercard _____Visa _____AmExpress _____Discover

Card Number _____

Exp Date _____

CVC Code _____

Billing Address _____

Signature _____