Santa Ana Skin Care Clinic

LEONORA LÓPEZ, MD

*Where Beautiful Skin Is Always In*

THE INFORMATION REQUESTED ON THIS FORM IS USED FOR OTHER IMPORTANT DOCUMENTATION. PLEASE PRINT LEGIBLY. THANK YOU

| Referring or Primary Care Physician or Friend (**FIRST AND LAST NAME)** | **OR:** How did you hear about us? |
|---|---|

## PATIENT INFORMATION

| Patient's last name: First: Middle Int: | ☐ Mr. ☐ Mrs. | ☐ Miss ☐ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|

| Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? | Preferred / Nickname: | Birth date: / / | Age: | Sex: ☐ M ☐ F |
|---|---|---|---|---|---|

| Street address: | |
|---|---|
| City: | State: ZIP Code: |

| Occupation: | Employer: | Work Phone #: | Home Phone #: | Cell Phone #: |
|---|---|---|---|---|

| Person responsible for bill: ***REQUIRED*** | D.O.B. ***REQUIRED*** / / | Address (if different): | Home phone #: ( ) |
|---|---|---|---|

| Occupation: | Employer: | Employer address: | Employer phone #: ( ) |
|---|---|---|---|

## IN CASE OF EMERGENCY

| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone #: ( ) | Work phone #: ( ) |
|---|---|---|---|

Thank you for choosing our office for all of your skin care needs. If at any time you have questions regarding your treatment, please feel free to call the office. Please note that treatment fees are due at time of services, and medical insurance may not cover treatments because they are considered a cosmetic luxury. Also note that results of products and procedures are not guaranteed. Also, all products and services offered through SASC are **non-refundable**.

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance.

_____ _____

Patient / Guardian Signature Date

ALLERGIC TO: _____ _____ _____

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## AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO INDIVIDUALS

_____ DOB:_____ SS#:_____
Name of Patient

I understand that Santa Ana Skin Care Clinic (SASC), from time-to-time, may be requested to disclose my protected health information (PHI) with members of my family, a caregiver or a close friend. Therefore, I authorize the following individuals to access or receive my PHI:

***Person's Name:*** ***Relationship to Patient:***

_____

_____

_____

I authorize SASC to disclose my PHI for the following purposes:

- ☐ Make, change or cancel an appointment for me
- ☐ Obtain test or lab results on my behalf
- ☐ Discuss my current health condition or symptoms
- ☐ Pick-up written prescriptions or pharmaceutical samples on my behalf
- ☐ Other:

_____
_____

**I understand that written authorization is required should any of the above named persons request copies of my medical records.**

**The following individuals are specifically NOT AUTHORIZED to access or receive any of my PHI:**

***Person's Name:*** ***Relationship to Patient:***

_____

_____

_____

I understand that if information is requested via telephone, the caller may be asked to identify me by (a) providing my social security number and my date of birth as shown on SASC's records, and (b) the caller's full name shown above. If the request is made in person, the individual may be required to provide proper identification, including a picture ID.

I understand that in order to add or delete designated people from this list, I must notify SASC in writing. I also understand that I may revoke this authorization in its entirety by providing written notification to SASC.

_____ _____
Signature of Patient Date Signature of Personal Representative Date

_____ _____
Printed Name of Patient Printed Name of Personal Representative

_____
Personal Representative's Relation to Patient

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**INFORMED CONSENT FOR BOTOX / DYSPORT / RESTYLANE / PERLANE / RADIESSE / JUVEDERM / ARTEFILL INJECTIONS**

**BOTOX / DYSPORT**

*Botulinum toxin Type A has been safely used for many years and is FDA approved for the treatment of facial muscle spasms resulting in crossed eyes and persistent eyelid twitching. Wrinkles of the skin above the nose, around the eyes, and over the brow can be produced by overactive muscles of facial expression. Injecting the medication into these tiny muscles can cause them to be temporarily weakened and halt their function, thereby improving the appearance of wrinkles. The cosmetic use of Botox has been FDA approved only for reducing wrinkles of the glabella frown line, but has been safely and commonly used for the purpose of reducing other facial wrinkles for many thousands of patients since 1987. The procedure is known as cosmetic denervation.

*Wrinkles that can successfully be treated include the frown lines, crow's feet, and lines of expression caused by muscle activity. This treatment will not work to eliminate wrinkles due to loose or sagging skin.

*The treatment may cause a rash or a brief headache, although many patients have reported a dramatic decrease in tension headaches once the muscles become relaxed by the Botox or Dysport. Very rarely the medication may spread to other nearby muscles and cause temporary ptosis (drooping) of an eyelid or unevenness of an eyebrow. These rare effects when they occur are not permanent and usually resolve completely within 2-4 weeks. In some patients, Botox does not work as well as anticipated or last as long as expected. A touch-up re-treatment usually brings improved results.

*Results are normally noticed within 7 days, but it may take as long as two weeks before the full effect of the treatment is realized. The effects usually last for 3-6 months, at which time the procedure may be repeated, if desired. It may take more than one treatment session to a given area to achieve full results.

**RESTYLANE / PERLANE**

*Restylane/Perlane is indicated for mid-to-deep dermal implantation for the correction of moderate to severe facial wrinkles and folds, such as nasolabial folds. It has also been given an FDA indication for use on the lips. It may take up to two weeks for the full effect of the treatment to be realized. The effects of this treatment usually last 6-9 months.

*Restylane/Perlane contain trace amounts of gram positive baceterial proteins, and is contraindicated for patients with a history of allergies to such material.

*If laser treatment, chemical peeling or any other procedure based on active dermal response is considered after treatment with Restylane/Perlane, there is a possible risk of eliciting inflammatory reaction at the implant site. This also applies if Restylane/Perlane is administered before the skin has healed completely after such a procedure.

**JUVEDERM**

***Juvederm is a colorless hyaluronic acid gel that is injected into facial tissue to smooth wrinkles and folds, especially around the nose and mouth. Hyaluronic acid is a naturally occurring sugar found in the human body. The role of hyaluronic acid in the skin is to deliver nutrients, hydrate the skin by holding in water, and to act as a cushioning agent.

*Juvederm is injected into areas of facial tissue where moderate to severe facial wrinkles and folds occur. Juvederm temporarily adds volume to the skin and may give the appearance of a smoother surface, and the results last for six months to one year. After the initial two weeks, patients may come back for touch-up treatments if desired.

**RADIESSE**

*Radiesse is an injectable filler that offers a non-surgical approach to shaping and contouring the face. This convenient treatment fills and corrects smile lines, nasolabial folds and wrinkles around the nose and mouth.

*Radiesse is made of unique calcium-based microspheres suspended in a natural gel that creates a scaffold through which the body's own collegen will start to grow, producing the desired long-term effect. Results can last up to eighteen months.

**ARTEFILL**

*Artefill is intended to be injected intradermally to improve and soften smile lines, nasolabial folds and wrinkles around the nose and mouth.

*Artefill is a sterile gel composed of 30 to 50 micron microspheres of Polumethylmethacrylate in a slurry of bovine (cow) collagen with diluted lidocaine, which is FDA approved for permanent filling and to improve the appearance of nasolabial folds.

*Artefill implants contain lidocaine and must not be used in patients with known lidocaine hypersensitivity.

*Artefill requires a negative skin test prior to the initial treatment.

*Artefill is a permanent filler, but may require 1-3 treatments for full results.

**BOTOX / DYSPORT / RESTYLANE / PERLANE / JUVEDERM / RADIESSE / ARTEFILL**

***The most common side effects associated with these treatments are bruising, swelling, redness, tenderness, indurations, and rarely acne from papules at the injection site.

*Patients who are using substances that can reduce coagulation (i.e. aspirin, ibuprofen, non-steroidal anti-inflammatory drugs, etc.) may, as with any injection, experience increased bruising or bleeding at the injection site(s).

*These treatments are a contraindication for patients with severe allergies manifested by a history of anaphylaxis or history or presence of multiple severe allergies.

*Use of these injections at specific sites in which an active inflammatory process (i.e., skin eruptions such as cysts, pimples, rashes, hives, etc.) or infection is present should be deffered until the inflammatory process has been controlled.

*These treatments should not be administered if you are pregnant, breast feeding, taking blood thinners, or have any neurological diseases such as Multiple Sclerosis or Myasthenia Gravis. The effects of these injections may be greater if you are taking certain aminoglycoside antibiotics such as gentamicin, tobramycin, spectinomycin, neomycin, kanamycin or amikacin. You MUST notify Dr. Lopez if you have any of these conditions or if you are taking any of these medications.

***I understand that these treatments, like the practice of medicine itself, are not an exact science. Therefore, no specific promises or guarantees of results can be made for any degree of improvement of my particular condition. There can be no refunds given for any treatment rendered.**

*I authorize the taking of photographs before and after treatment to be kept in my file. Photographs help to document my progess.

*I acknowledge that Dr. Lopez, or any provider associated with SASC, administers Botox, Dysport and fillers for cosmetic purposes ONLY which is NOT covered by insurance.

I certify that I have read and understand this document in its entirety. I certify that I do not have any medical conditions or take any medications that would have any effect on this procedure as mentioned above. I voluntarily authorize Dr. Lopez or any medical provider associated with Santa Ana Skin Care Clinic, with or without an assistant, to administer Botox, Dysport, Restylane, Perlane, Juvederm, Radiesse, Artefill or any other filler-type injections.

Responsible Party Signature: _____ Date: _____

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**PROCEDURE AGREEMENT FORM**

___ Initials Prior to receiving treatment, I have been candid in revealing any conditional that may have bearing on this procedure such as: pregnancy, recent facial surgery, allergies, cold sores/fever blisters, use of medication, etc.

___ Initials I understand that there may be some degree of discomfort, i.e., stinging, pin pricking, hotness, tightness, etc.

___ Initials I understand there are no guarantees as to the results of this treatment due to the many variables such as: age, condition of skin, smoking, etc.

___ Initials I understand that I may or may not actually peel, that each case is individual.

___ Initials I understand that the treatments performed here are considered cosmetic, and will not be covered by insurance.

___ Initials I understand that to achieve maximum results, I may need several treatments.

___ Initials I understand that although complications are very rare, they may still occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the doctor or aesthetician who performed the treatment.

___ Initials I agree to refrain from tanning booths while I am undergoing treatment and during the twenty-one days following the end of treatment.

___ Initials I understand that direct sun exposure is prohibited while I am undergoing treatment, and the use of sun block with a minimum SPF 15 is mandatory.

___ Initials I have not had any other peel treatment of any kind within 14 days of the treatment. I understand I cannot have another treatment within 14 days of this treatment, whether the treatment is performed at this location or at any other location, unless directly expressed otherwise by the doctor or aesthetician.

___ Initials I understand that if additional units of Botox or additional filler injections are needed, I will be charged additional costs at regular price.

**I hereby agree to all of the above statements and have answered truthfully and to the best of my knowledge. I give consent to have treatment performed on my. I further agree to follow all post-care instructions as I am directed.**

_____ _____

Signature Date

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**MEDICAL HISTORY FORM FOR COSMETIC INJECTIONS**
**BOTOX / DYSPORT / RESTYLANE / PERLANE / RADIESSE / JUVEDERM / ARTEFILL**

What is the reason for today's visit? _____

What medications are you allergic to? _____

Please list any other allergies you have: _____

What medications are you currently taking? _____

Please list any past surgeries you have had: _____

Please check all that apply:

Are you pregnant? ☐ Yes ☐ No

Are you taking antibiotics? ☐ Yes ☐ No

Are you taking any blood thinners? ☐ Yes ☐ No
(*includes aspirin, ibuprofen, vitamin E, etc.)*

Do you smoke? ☐ Yes ☐ No

Have you had Botox treatments before? ☐ Yes ☐ No
If yes, what was the date of your last treatment? _____

Have you had collagen treatments before? ☐ Yes ☐ No
If yes, what was the date of your last treatment? _____

Do you have muscular or nervous system disorders, such as Multiple Sclerosis or Myesthenia Gravis? ☐ Yes ☐ No

Do you have a regular fitness program? ☐ Yes ☐ No

Do you work out using weights? ☐ Yes ☐ No

Do you get headaches or migraines? ☐ Yes ☐ No

Do you have any neurological disorders? ☐ Yes ☐ No
Please specify: _____

Do you have asthma/lung disease? ☐ Yes ☐ No

Do you have hepatitis/liver disease? ☐ Yes ☐ No

Do you have kidney/bladder disorder? ☐ Yes ☐ No

Do you have diabetes? ☐ Yes ☐ No

Do you have leg/ankle ulcers? ☐ Yes ☐ No

Do you have arthritis? ☐ Yes ☐ No

Do you have cancer? ☐ Yes ☐ No
Please specify: _____

Do you get skin rashes easily? ☐ Yes ☐ No

Do you have Phlebitis? ☐ Yes ☐ No

Do you have varicose or spider veins? ☐ Yes ☐ No

Do you have keloid scars? ☐ Yes ☐ No

Do you have any other medical conditions that we should be aware of?

_____

I certify that the information that I have provided above is accurate to the best of my knowledge. I understand that the treatment plan proposed for me and the results I can expect are partially based on the accuracy of the information that I have provided. I understand that results of these procedures cannot be guaranteed.

Responsible Party Signature: _____ Date: _____

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**CANCELLATION / RESCHEDULE / NO SHOW POLICY**

Failure to keep scheduled appointments is costly to our practice and to other patients. Patients who are not able to keep their scheduled appointments are required to provide timely notice of reschedule or cancellation prior to their appointment time. (See below.) Providing the required notice gives us the opportunity to schedule patients from a wait list so they may be seen sooner.

***Any patient who DOES NOT provide required notification of reschedule or cancellation to the staff at SASC is subject to a Cancel / Reschedule / No Show Fee that is not covered by insurance companies.***

Due to the nature of services provided, required no-show fees and required notice varies by treatment length. Patients will be informed of fee requirements when appointments are confirmed prior to the scheduled time. A phone number will also be given for providing notification for either cancellation or rescheduling.

| | | |
|---|---|---|
| • **Office Visits / Consultations** | **1 Business Day** | **$50** |
| • **Aesthetic Treatments (Non-Fraxel)** | **1 Business Day** | **$50** |
| • **Fraxel Laser Treatments** | **2 Business Days** | **$150** |

**Patients FAILING TO PAY the above fee will not be allowed to schedule future appointments and will be sent to collections. Multiple Reschedules, Cancellations, or No Shows may result in dismissal from our practice.**

****To Cancel or Reschedule Clinic Appointments, please call (505) 954-4422, EXT. 101****

**Signed:**_____ **Date:**_____

**(Copy to Patient Upon Request)**

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**FINANCIAL POLICY**

Please read our financial policy and indicate your agreement by your signature. We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. All patients must complete the appropriate forms before seeing a skin care provider.

**FULL PAYMENT IS DUE AT THE TIME OF SERVICE**.
We accept cash, check, Visa, American Express, Discover, Mastercard & Care Credit.

Private pay patients: Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan or paid by cash, check, or credit card at the time of services.

Insured patients: If you have insurance, we will help you obtain benefits for covered services. If you have insurance with a company for which we are not providers, we will give you properly completed "super bills" so that you can file your own insurance claims and be reimbursed to the extent of your coverage. We only file claims to insurance companies that we are participating providers for. Filing a claim is not a guarantee of payment. Many of our services are considered to be a cosmetic luxury and are therefore not covered by insurance. You are responsible for the full payment of any denied claims. We provide Botox for cosmetic purposes only, which is NOT covered by insurance.

Insurance: This is a contact between you and your insurance company. In many cases, we are not a party to this contract. We will inform you if we are a party to your contract, and we will handle your claims according to our agreement with your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance usual and customary charges, etc., other than to supply actual information as necessary. In the event that you receive a statement with a balance due after insurance adjustments, you are responsible for timely payment on your account.

Balance due terms: Your signature below indicates your agreement with our terms for any unpaid balance due. Any unpaid balances to customer accounts are subject to being sent to a collection agency after repeated statements are sent to the address provided by the patient. If it becomes necessary to employ an attorney or collection agency to collect an unpaid balance due, those fees will be added to the balance due.

Notice: All products and services offered through Santa Ana Skin Care Clinic are non-refundable.

Responsible Party Signature: _____ Date: _____

Santa Ana Skin Care Clinic

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**PRIVACY POLICY**

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice summarizes how we handle your information, and provides further details of our privacy policies and procedures.

**How we may use and disclose your information:** We use health information about you for your treatment, to get paid for treatments, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for these reasons. Beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it in writing to stop further uses or disclosures.

**Your rights:** In most cases you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we will charge you a cost-based fee and these copies will be made within 30 days. You also have the right to request a list of certain types of disclosures of your health information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

**Our legal duty:** We are required by law to protect the privacy of your health information; provide this notice about our privacy policies; follow the privacy practices that are described in this notice; and seek your acknowledgement of receipt of this notice. We may change our privacy policies at any time.

**Privacy complaints:** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

**If you have any questions or complaints, please contact:**

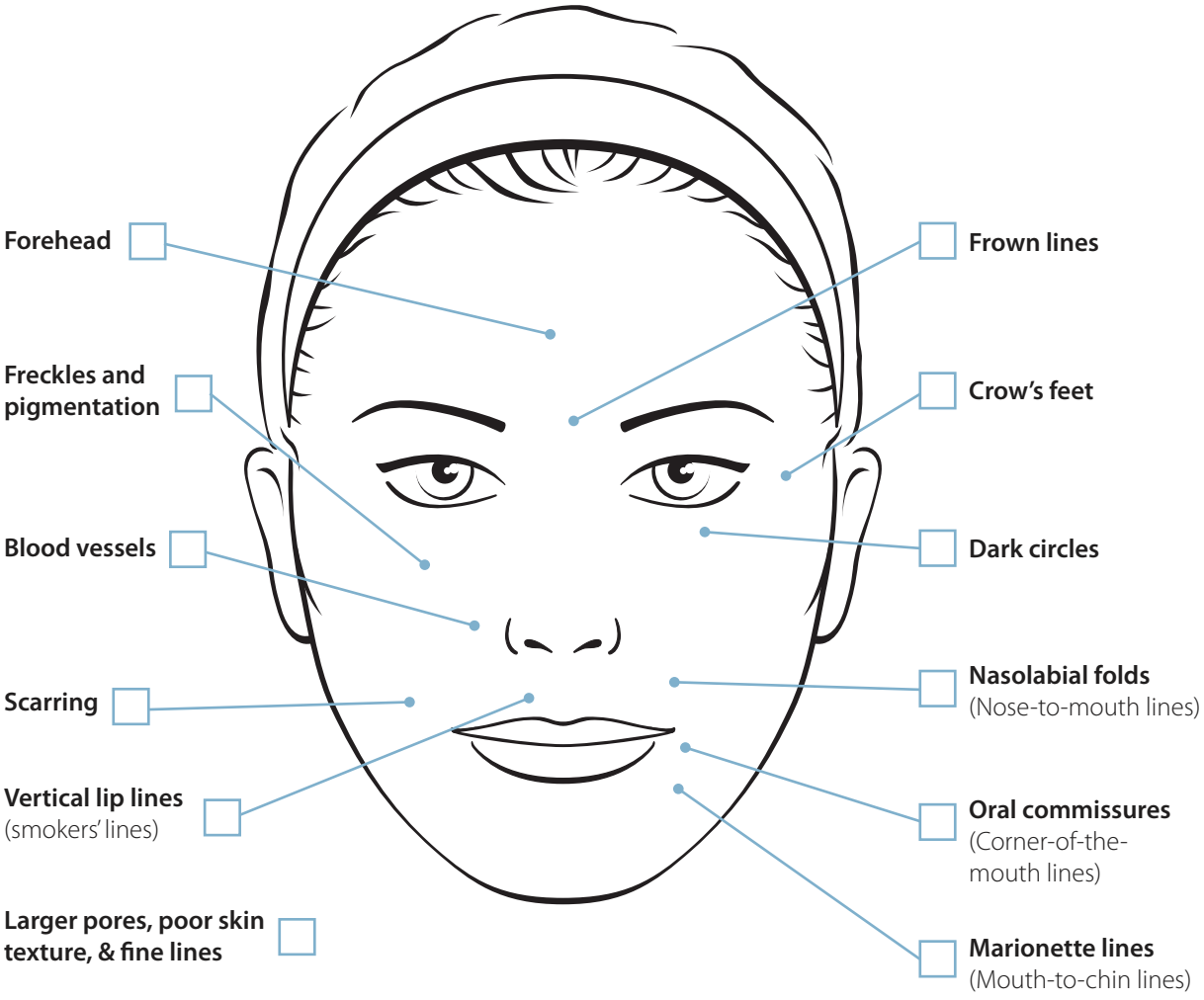
Office Manager
Santa Ana Skin Care Clinic, PC
2205 Miguel Chavez
Suite E
Santa Fe, NM 87505

(505) 954-4422

Responsible party signature:_____ Date:_____

## Facial Anatomic Representation

With respect to facial aesthetics, please highlight those areas of the face that bother or trouble you. In the boxes provided, please rate these areas on a scale of 1 to 5 (1 being least bothersome, 5 being most bothersome). Feel free to draw on the chart to identify any other facial concerns.




Thank you for completing this questionnaire.

Form courtesy of Medicis Aesthetics Inc.
AES 10-073 01/31/12