Patient Information
Drops of Beauty Anti-Aging Medical Spa

Last Name:_____ First Name:_____ M.I._____.

Date of Birth:____/____/_____ Address:_____.

City:_____ State:_____ Zip:_____ Phone Number: (___)_____.

E-mail:_____.

Emergency Contact:_____ Phone Number:_____.

How did you hear about our spa? (Please specify)_____.

Assignment of Financial Responsibility

I agree that I am responsible for the charges in full for services rendered. I agree to pay all finance charges, billing charges and all collection fees that may be incurred to collect any balance that may be owed.

Cancellations and Refund Policies

TREATMENTS: All treatments, procedures and/or prepaid packages are non-refundable. Packages are non-transferable and must be used within one year from the date of purchase. Credit from prepaid treatments, procedures, and/or packages may be applied toward other forms of treatment(s) or product(s) only at management's discretion. Credit can be given to and used by purchaser only. **NO REFUNDS - EXCHANGES ONLY.**

PRODUCTS: Many of the products sold in our practice are considered "medical grade" products, and can only be purchased from, or sold by, a licensed professional. We do not accept returns on any product. A spa credit may be issued depending on the circumstance and is at management's discretion. Your signature on this document serves as your acceptance and understanding of our "no return" policy. A copy of this document will be kept in your chart and is available for your review at any time.

CANCELLATIONS: We understand that emergencies do arise; however, we request a 24-hour notice for rescheduling or canceling all appointments. Failure to do so may result in a charge on your account.
"NO SHOWS" WILL BE BILLED FOR THE SCHEDULED TREATMENT.

APPOINTMENTS: To ensure your preferred Doctor or Technician is always available to you, we recommend scheduling your next appointment prior to leaving the Medical Spa. This is particularly important if you are having a series of treatments over a defined period of time. We will always try to schedule you with your requested provider, however, sometimes that provider will not be available and we will place you with our best recommendation.

ARRIVALS: Please arrive on time for your scheduled appointment. This ensures adequate timing for your well-deserved treatment and helps us in not intruding on the following clients' reserved time.

By signing below, I agree to the company's terms and conditions.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

PERSONAL PROFILE & MEDICAL HISTORY (1/2)

Name: _____ Date of Birth: _____

Females: Are you pregnant? ___Yes ___No Are you breastfeeding? ___Yes ___No

Your genetic background affects your skin and its response to many of our procedures. Please specify your ethnic origin:

_____ African American _____ Asian _____Caucasian ____Hispanic
_____ Mediterranean _____ Middle Eastern _____ Native American ____Other_____

Complete the following items of medical history. Please, always inform us of any changes in your medical history and/ or medications.

Please list **all medications** including prescription and over the counter drugs, vitamins, herbs, **blood thinners, aspirin,** and/or supplements.

_____

_____

Allergies to medications?

_____

Please check if any of these conditions apply to you

____ Acne	_____ High Blood Pressure	_____ Precocious Puberty
____ Bleeding Disorders	_____ Hirsutism	_____ Psoriasis
____ Burns/Skin Grafts	_____ Hormone Replacement Rx	_____ Rosacea
____ Claustrophobia	_____ Cold Sores	_____ Implants
____ Seizures	_____ Diabetes	_____ Kaposi's Sarcoma
____ Shingles	_____ Eczema	_____ Keloid Scars
____ Skin Cancer	_____ Endocrine Disorders	_____ Lupus Erythematosus
____ Tattoos	_____ Epidermolysis Bullosa	_____ Thyroid Disease
____ Gold Therapy	_____ Polycystic Ovary Disease	_____ Vitiligo
____ Heart Disease	_____ Port- Wine Stain	_____ Permanent Makeup
____ Herpes	_____ Hepatitis	_____ HIV/ AIDS

Have you suffered from any neurological illness in your past? If yes, please specify:

____ ALS ____ MS ____ Guillain Barre' ____ Myasthenia Gravis

Other:_____

Have you ever had surgery? If yes please specify:

_____

Please describe any other pertinent medical information:

_____

_____

PERSONAL PROFILE & MEDICAL HISTORY (2/2)

If the answer to any of the following questions is yes, please provide details.

1. Have you used Accutane in the last 6 months? Yes No
   a. If yes, how recently? _____
2. Are you currently using glycolic acid or Retin A? Yes No
3. What products are you currently using on your skin? Please describe: _____
_____
4. Do you have any active skin diseases or infections in the area to be treated? Yes No
5. Are you allergic to latex, lidocaine, or any lotions? Yes No
6. Have you had any permanent cosmetic tattooing to the area to be treated? Yes No
7. Do you have any metal or other implants? Where? Yes No
8. Have you had any previous laser or other skin treatments on the area to be treated? Yes No
9. Are there any moles with hair in the area to be treated? Yes No
10. Do you have any history of skin breakouts? Yes No
11. Do you have any scarring as a result from breakouts/acne? Yes No
12. Have you been exposed to the sun within the last four to six weeks? Yes No
    a. If yes, state the approximate date of last exposure _____/____/____
13. Do you use tanning beds. If yes, state the date of last use _____/____/____
14. Do you burn easily in moderate sunlight? Yes No
15. Do you blush easily when nervous? Yes No
16. Do you frequently experience flakiness, tightness or dryness? Yes No
17. Do you use sunscreen on a regular basis? Yes No
18. Have you waxed, used depilatories, bleaches or other chemical processes? Yes No
19. How many glasses of water do you usually drink in a day? _____
20. Do you smoke? Yes No
21. Do you wear contact lenses? Yes No
22. Do you exercise? Yes No
23. Have you had microdermabrasion? Yes No
24. Have you had any chemical peels? Yes No
25. Have you had laser resurfacing? Yes No
26. Do you have wrinkle concerns? Yes No
27. Do you have scarring concerns? Yes No
28. Do you have sun damage concerns? Yes No
29. Do you have pigmentation concerns? Yes No
30. Do you have broken capillary concerns? Yes No

What services are you most interested in? _____

_____

Name of your Primary Care doctor: _____ Phone #: (_____) _____

I confirm that the answers to the questionnaire are true and correct.

Print Name: _____

Signature: _____ Date: _____
(Parent or Guardian if patient is under 18)

Drops of Beauty Medical Spa Office Policies

At Drops of Beauty Anti-Aging Medical Spa we strive to ensure the highest quality of care and comfort. Our policies have been designed to provide a truly relaxing and tranquil environment. Come join us to *Relax. Restore. Renew.*

Punctuality

Please arrive at least 15 minutes before your scheduled treatment for check-in and any possible clothing changes. If you happen to be late we offer two choices.

- You may shorten your treatment because of time constraints and other clients' schedules.
- You can reschedule your appointment with a $25 cancellation fee to accommodate our professionals.

In case of prepaid vouchers your single treatment will be forfeited. If you would like to reinstate that treatment, a fee equal to the single treatment will apply.

Cancellation Policy

Drops of Beauty Medical Spa understands that you may have to cancel an appointment sometimes. However, we require that a 24-hour notice must be given. Failure to do so will result in a $25.00 charge of your scheduled treatment to your credit card.

Payments

Our available payment options are credit and debit cards (including American Express), cash, Discover and gift certificates.

Gift Certificates

Gift Certificates are available at the reception desk or through the med spa coordinator at the time of your consultation. Gift Certificates are required at the time of service and must be redeemed within one year from the date of purchase.

Tipping and Gratuity

Gratuity is greatly appreciated. Gratuity is not included in your spa treatment certificates, prepaid vouchers or cosmetic procedures. Typical gratuity is 20% of full service price (usually $20 minimum). Gratuity is appreciated for touchups and for complimentary services.

Children and Cell Phone Courtesy

Drops of Beauty Spa is a tranquil environment. To preserve the serenity, please do not bring children to your scheduled appointments and turn off all cell phones. Thank You.

Refunds

No refunds will be given on products, services, and gift certificates. This includes prepaid services including Botox/Dysport and fillers, all retail and all services.

Exchange of Series, Packages and Programs

When purchasing a series of treatments or bundled packages, a discounted rate is given at the time of purchase; payment must be made at the beginning of treatment. The series are non-refundable, and non-transferable. However, should you choose during your series to opt for a different service any remaining balance may be applied to a different treatment. When canceling a series, we deduct full price of used services.

_____

Acknowledgement Signature Date

Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All claims Must be Arbitrated: It is also understood that any dispute that does not related to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a backup for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's prorated share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute the right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to intrude evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgement for future agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should **Initial Here____.** Effective at the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Print Name_____

Office Signature_____ **Date**_____

Botox/Dysport Consent Form

To the patient: You have the right to be informed about your treatment so that you may take the decision to undergo the procedure, knowing the risks and hazards involved.

I _____ have received a consultation with Drops of Beauty Medical Spa and I consent to having Botox/Dysport treatment carried out upon myself for the improvement of _____ _____ .

Botox is injected with a small needle into the muscle, with the aim of inhibiting the underlying muscle contraction, therefore improving facial lines and appearance.

I have been informed about the treatment. procedure, indications, expected results and possible side effects. I understand that I may experience swelling, redness, tenderness, slight headache, pain and/ or bruising that may occur for several days after my treatment, however these symptoms will resolve. Rarely an adjacent muscle may be weakened for several weeks after injection. I have been advised of the risks involved and the expected benefits of Botox treatment.

I have been given and read the post treatment instructions and agree to follow these instructions. _____(initials)
Although the results are usually dramatic I have been informed that the practice of medicine is not an exact science and that no guarantees can be or have been made concerning the expected results in my case. I am undergoing treatment of my own free will. I agree that his procedure is being performed for cosmetic reasons and that no guarantee can be made as to the exact results of this procedure. I understand that whilst every precaution will be taken to prevent complications and that whilst complications from this procedure are rare, they can and sometimes do occur.

I accept responsibility for any complications that may occur and thereby absolve Drops of Beauty Medical Spa any associated person of any blame resulting there from.

I understand that I am required to have photographs taken before, during and after treatment for my medical records.

- ❑ I hereby grant Drops of Beauty Medical Spa permission to use my likeness in a photograph in any and all of its publications, including website entries, without payment or any other consideration.

- ❑ I hereby grant Drops of Beauty Medical Spa permission to use my photographs for my medical records only.

I understand and agree that these materials will become the property of Drops of Beauty Medical Spa and will not be returned. I hereby irrevocably authorize Drops of Beauty Medical Spa to edit, alter, copy, exhibit, publish or distribute this photo for purposes of publicizing Drops of Beauty Medical Spa's programs or for any other lawful purpose. In addition, I waive any right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive my rights to royalties or other compensation arising or related to the use of the photograph. I hereby hold harmless and release and forever discharge Drops of Beauty Medical Spa, from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization. I am 21 years of age and am competent to contract in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release. I agree that this constitutes full disclosure, and that is supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

I understand that the terms of payment require full settlement on or before the day of my treatment.

Patient Signature_____ Date _____

Witness Signature _____ Date _____

Botox and Dysport Instructions

Pre-Procedure Instructions

Avoid taking Aspirin, Non- steroidal Anti-inflammatory Drugs (NSAIDS) such as Motrin, Vitamin E, GInger, Ginkgo Biloba, Ginseng, and Garlic 10-14 days prior to procedure. These drugs and herbs may cause excessive bleeding or bruising.

We recommend waiting two weeks after all dental work (dental cleaning included) before getting Botox/Dysport due to a higher risk of infection.

Post Treatment Instructions

1. Avoid applying pressure or massaging the treated areas for a few hours after the procedure. This may disperse the Botox/Dysport into undesired area.

2. Avoid lying down or bending over for 4 hrs. after treatment as this may allow Botox/Dysport to disperse in undesired directions.

3. Avoid strenuous exercise after the procedure. This may raise your blood pressure and pulse causing more bruising and swelling.

4. Avoid heating the body core temperature (hot bath, hot shower, sauna, Jacuzzi) as this may allow Botox/Dysport to disperse in undesired directions.

5. You may apply makeup after the procedure.

6. You may apply cold compresses to the treatment sites to reduce swelling and bruising.

7. We recommend a Vitamin K cream or Arnica Montana to treat any bruising, fresh pineapple is also helpful.

8. Note that any bumps or marks from the extremely small needle sticks will go away within a few hours. If you do develop a bruise it will resolve like any other bruise. 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.

9. 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.

10. Botox/Dysport Cosmetic is a temporary procedure. In most people, the benefits of Botox/Dysport last about 3-4 months. Sometimes a few wrinkles may start to return in 2-3 months.

11. Avoid airplane flights for 24 hrs. After treatment as this may allow Botox/Dysport to disperse in undesired directions, due to the pressure in the cabin of the airplane in flight.

12. DO NOT WEAR hats or headbands of any type 4 hours post Botox/Dysport.