# PERSONALIZED GOALS

## I WANT TO:

- [ ] Look less saggy
- [ ] Look more attractive
- [ ] Look slimmer
- [ ] Look perfect
- [ ] Look less angry/more approachable
- [ ] Look sexier
- [ ] Look less like my older relatives
- [ ] Look more feminine
- [ ] Look like I can compete in the workplace
- [ ] Look more masculine
- [ ] Look younger
- [ ] Look less tired
- [ ] Look perfectly symmetrical
- [ ] Look more vibrant
- [ ] Look like I didn't spend days in the sun
- [ ] Fix one particular flaw
- [ ] Look 20 again

Facial Art
INSTITUTE, LLC

Name: _____

_____

Date of birth: _____/ _____/_____ Social Security #: _____-_____-

_____

Address: _____ City: _____ State: _____ Zip:

_____

## Medical History

Please circle any of the following that you have OR have had:

High blood pressure

Diabetes

Stroke

Heart disease

GERD

Organ transplant

Skin conditions (eczema, rosacea, etc.)

Hemophilia or other blood disorders

Neuromuscular disease

Keloid scarring

Lung disease

Kidney disease

Thyroid disease

Anemia

Asthma, COPD, Emphysema, other lung issues

Cancer

Headaches

Liver disease

Herpes simplex

AIDS / HIV

Pigmentary issues hyper / hypo

Any autoimmune disease (lupus, MS, etc.)

Hormonal disorders

Very dry skin

Bleeding disorders

Alopecia

Shingles (less than 6 months ago)

Other:

_____

_____

_____

## Social History

Occupation: _____ Marital Status: _____ Regular exercise: _____

## How did you hear about our services?

_____

## Medical History Continued

Please circle any of the following symptoms you have or have had in the last year:

- Fever, chills, night sweats, weight loss, appetite change, fatigue, weakness
- Bleeding gums, nose bleeds, easy bruising
- Seizures, migraines, headaches, depression, anxiety, insomnia, memory loss, dizziness, slurred speech
- Sinus problems, hoarseness, cough, shortness of breath, bloody cough, wheezing
- Chest pain / discomfort, palpitations, difficulty breathing, fainting, hand / ankle swelling
- Difficulty swallowing, heartburn, abdominal pain, nausea, vomiting, diarrhea, constipation, rectal bleeding, black stools

Do you wear contacts/glasses? _____ Use Accutane? (Within 6 months)

_____

Use photosensitizing medication? _____Are you currently pregnant or breast-feeding?

_____

Have an active infection? _____

Please list all surgical procedures:

_____

_____

_____

List all medications, including over the counter, cannabinoids and supplements?

_____

_____

_____

_____

Do you have a reaction to any type of medication or contact with any substances including, latex or adhesives

Do you regularly use Retinol-A, Glycol or any other exfoliating product? If yes, please list: _____

_____

_____

Have you received any skin boosting / skin rejuvenation treatment before? If yes, please answer the following questions:

What procedure did you receive? _____ When was your treatment?

_____

Have you had surgery (laser or other) on the area being treated in the last 3 months? _____

When were you last exposed to the sun? (Include tanning bed) _____

Do you use chemical tanning lotion?

_____

Do you use sunscreen? _____ If yes, what SPF?

_____

Do you scar easily? _____ Do you heal easily?

_____

Please circle which skin type best describes you after being exposed to the sun for 1 hour with protection:

I certify the preceding medical and personal statements are true and correct. I am aware that it is my responsibility to inform the technician, company or any staff at Facial Art Institute of my current medical health and to update them in the event of any changes.

Client Signature: _____Date:

_____

## Financial Policy

It is our policy that all prepayments/payments for your services are nonrefundable and nontransferable. We understand that circumstances beyond your control may arise which would prevent you from ever starting or completing your treatment. In these cases, we will evaluate these circumstances on an individual basis. Products and services are to be redeemed within one year of this dated contract or all prepayments are forfeited.

## Photography Authorization

We will use photographs for comparative purposes before and after certain treatments. These photos are to be used solely for the purposes stated above and are not to be published for any reason unless proper consent from the patient is discussed and obtained.

Patient/Guardian Signature:

_____ Date: _____

Facial Art
INSTITUTE, LLC

*Printed Name:* _____

*Relationship to Patient:* _____

# Consent for Neurotoxin

Patient Name: _____ _____Date:_____

To the patient: You have the right to be informed about your skin condition and treatment so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you. It is simply an effort to better inform you so that you may give or withhold your consent from this treatment program.

I have requested this attempt to improve my facial expression lines with neurotoxin. These injections have been used for more than a decade in children and adults to improve the problem of muscle spasm of the facial muscles. This toxin has also been useful to correct double vision due to muscle imbalance. Injects of minute amounts weaken the muscle and prevent frowning, crow's feet, and expression lines. 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, or have been made concerning expected results in my case.

Initial if true_____

The solution is injected with a small needle into the muscle. You see the benefits develop over the next 5-7 days, with full benefits at 14 days. Less frowning will be possible.

Initial if true_____

Side effects and complications are usually minimal. Occasionally, slight swelling and/or bruising may last for several days after the injection. I have been advised of the risk in such treatments, the expected benefits of such treatments, and alternative treatment, including no treatment at all.

Initial if true_____

I understand the most significant risk could be a drooping brow or eyelid, or weakness in the muscle that closes the eye, if adjacent muscles are affected by the injection. This will usually resolve after several weeks.

Initial if true_____

I understand that the injection of neurotoxin is temporary, but that after multiple injections there may be permanent effects.

Initial if true_____

I understand more than one injection may be needed to achieve a satisfactory result.

Initial if true_____

I understand the contraindications to this treatment include pregnancy, bleeding disorders, neuromuscular disorders, significant cardiovascular disorders, and allergies to albumin (egg) products. I understand the contraindications and I possess none of these conditions.

Initial if true_____

I understand that funds paid are non-refundable.

Initial if true_____

I agree that this constitutes full disclosure and it 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 and to ask questions.

Initial if true_____

**FIRST PROCEDURE**

Patient Signature: _____Date:_____

Practitioner Signature: _____Date:_____

**SECOND PROCEDURE**

I have re-read and understand the consent above. If I have questions, they have been answered to my satisfaction.

Patient Signature: _____Date:_____

Practitioner Signature: _____Date:_____

**THIRD PROCEDURE**

I have re-read and understand the consent above. If I have questions, they have been answered to my satisfaction.

Patient Signature: _____Date:_____

Practitioner Signature: _____Date:_____

**FOURTH PROCEDURE**

I have re-read and understand the consent above. If I have questions, they have been answered to my satisfaction.

Patient Signature: _____Date:_____

Practitioner Signature: _____Date:_____

**FIFTH PROCEDURE**

I have re-read and understand the consent above. If I have questions, they have been answered to my satisfaction.

Patient Signature: _____Date:_____

Practitioner Signature: _____Date:_____

# FACIAL ART INSTITUTE LLC

## Post Injection Instructions for Neurotoxin

### What to Expect:

1. You will start to see results 3-5 days after injection with maximum results in two weeks. Please allow two full weeks to appreciate the results and to determine if more treatment is needed.
2. Treatment may last 3 months or more. They may be repeated after this timeframe. Over time, the muscles will be retrained and less frequent treatments may be required.

### Do Not:

1. Do not rub or scratch area where the Neurotoxin was injected, which may cause migration of the Neurotoxin out of the desired are.
2. Do not exercise for at least 4 hours after injections. (walking is acceptable)
3. Do not lie flat for at least 4 hours after injections.
4. Do not drink alcohol or take non-steroidal medicine such as ibuprofen or aspirin for at least 4 hours after injections.

### Do:

1. Sit up for at least 4 hours.
2. Accentuate the movement in your face that was treated with the Neurotoxin.
3. Enjoy your fresh new look and say thank you to all compliments.