Wallingford Medical Associates

850 N Main St Unit 1 D2 Wallingford, CT. 06492

Phone: (860) 245-4126 Fax: (877) 927-0171

PATIENT INFORMATION (Please Print)

Patient's Name (Last) _____ (First) _____ (MI) _____

Mailing Address _____ City, State, ZIP _____

Physical Address _____ City, State, ZIP _____ ☐ Same as Mailing Address

Phone Numbers: Home ( ) _____ Cell Phone ( ) _____

Date of Birth (MM/DD/YYYY) _____/_____/_____ Sex ☐ Male ☐ Female ☐ Transgender

Social Security Number __NOT_-_NEEDED_-_For Cosmetics____ E-mail Address

_____

EMERGENCY CONTACT INFORMATION (information used for emergencies only)

Emergency Contact Name _____ Phone Number ( ) _____

Emergency Contact Relationship to Patient _____

PRIMARY PHARMACY INFORMATION (in case we need to send RX's)

Pharmacy Name _____ Phone Number ( ) _____

Address _____ City; State; Zip _____

HIPAA (Health Insurance Portability and Accountability) (please answer)

May we phone, email, or send a text to you to confirm appointments? ☐ Yes ☐ No

May we leave a message on your voicemail? ☐ Yes ☐ No

May we discuss your medical condition with anyone? ☐ Yes ☐ No

If yes, please name provide name and relation:

Name: _____ Relation: _____

Name: _____ Relation: _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

INFORMED CONSENT FOR BOTULINUM TOXIN INJECTION (BOTULINUM TOXIN TYPE-A AS DYSPORT® FROM GALDERMA) FOR THE TEMPORARY TREATMENT OF SUPERFICIAL FACIAL WRINKLES.

Please initial after each statement and sign at the bottom.

Dysport® is the botulinum toxin and works by paralyzing nerves and muscles.

1. I, _____, consent to and authorize Christopher Anderson, NP to perform a treatment of facial wrinkles with Dysport. _____

2. I am fully aware of a no-show fee of $50.00 that will be charged to the card I have on file if I do not show to scheduled appointment or call prior to appointment to reschedule or cancel within 24 hours of the appointment time _____

3. 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. _____

4. I understand surgery or other treatment alternatives may be as effective or more effective in reducing the appearance of wrinkles. _____

5. 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

Allergic reactions

The effects of Dysport® are apparent 2-5 days after treatment

The effects usually last 4-6 months. Periodic retreatment will be necessary to maintain the effects of Dysport®

Repeated treatment may lead to permanent loss of muscle tone in the treated area

Bruising

Facial asymmetry

Paralysis leading to droopy eyelids and double vision

Some patients may experience weakness or flu-like symptoms

Visual problems

Dry Eyes

Some patients may develop antibodies to Dysport®

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 Dysport®. _____

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. _____

7. No guarantee, warranty or assurance has been made as to the treatment results _____

8. I will hold Mystic Medical Associates, or Christopher Anderson, NP completely harmless from all and any litigation or claims made should I have any adverse reaction to Dysport® or reaction to Dysport®. Mystic Medical Associates or Christopher Anderson, NP maintain the right, under all circumstances and without penalty, to not perform the procedure should the decision be made.

9. If you are planning a LASIK® procedure, please inform the instructor as your Dysport® may be deferred. _____

10. I consent to allow personnel of Wallingford Medical Associates to take photographs and videos during the course of my therapy. Photos and videos may be used for showing the benefit of the procedures done at Mystic Medical Associates to other clients or potential clients. The photos and videos may be used for social media channels, for documenting before and after results, for medical education, to offer other clients options and/or for the professional evaluation of treatment progress. You may request that the photos and videos not show your identity (cover eyes and/or face) by selecting below. Names are never provided with photos and videos but comments on the photos and videos are possible by viewers or outside parties.

_____ I CONSENT TO ALLOW PHOTOGRAPHS AND VIDEOS AS DESCRIBED ABOVE

_____ I CONSENT TO ALLOW PHOTOS AND VIDEOS WITHOUT SHOWING MY IDENTIFYING FEATURES (EYES AND FACE)

_____ I DO NOT CONSENT TO ALLOW PHOTOGRAPHS OR VIDEOS.

11. I understand that the results are of a temporary nature, and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions described here including: _____

o No laying down or reclining for four hours after injection

o No scratching or rubbing the injected area

o No bending forward for four hours

o 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 express written consent. Further, this agreement does not expire.

12. I agree to pay in full for the above-mentioned services. _____

Card on file: ___(not needed for private parties)_____

Patient Name (please print) _____

Signature _____ Date_____

Provider Signature _____Date_____