ForeverYou

An Aesthetic Medical Corporation

Welcome!! And thank you for joining the ForeverYou community! On the following pages you will find **four forms** you need to complete before treatment can begin.

- √ **Patient Questionnaire** – a form that asks for for typical patient information.
- √ **Patient Medical History** – a form that asks for typical medical information.
- √ **Informed consent** – a form that describes the terms and conditions of receiving treatment.
- √ [This form is currently unavailable online – you will complete it upon arrival at ForeverYou]

The information in all these form is **highly confidential** and your personal information is protected and will not be released **without your expressed, written permission.**

Once you have downloaded these forms, **please fill out in advance of you first office visit.** In so doing, we can reduce the amount of time we need to spend on forms and get right to assisting you become your best self.

Thanks!!!

Maureen Barrett, RN

ForeverYou

An Aesthetic Medical Corporation

Patient Questionnaire

Name: _____
(First) (Last)

Address: _____
(Street)

_____ _____ _____
(City) (State) (Zip)

Cell Phone: (_____) _____ - _____ **Alternate phone number** (optional): (_____) _____ - _____

Email: _____
By providing a cell phone and email address, you agree to receive electronic communications from ForeverYou.

Gender: M F **Date of Birth**_____/ _____/ _____ **Current Age** _____

Who can we thank for referring you? _____ _____
(First) (Last)

Emergency Contact Information; Name:_____ Phone (_____) _____ - _____

How did you hear about us?

____ Friend/Acquaintance
____ Newspaper
____ Website
____ Seminar
____ Other: _____

What procedures are you interested in:

____ Botox/Dysport
____ Dermal Filler
____ Permanent Makeup

Consent for Photography

Required:

I understand that **before** and **after** photographs will be taken for the purpose of photo documentation and will be filed in my medical file. _____
Initial

Optional:

I give permission to release my photographs to be used for educational purposes. This may include presentations to patients or potential patients. **Circle one:** Accept/Decline _____
Initial

I give permission for my photographs to be considered for promotional purposes including print and/or website publications. I understand I will be contacted **prior to the use of my photos** and **given the opportunity to decline permission at that time**. If my picture is published, I understand that my name will never be used.
Circle one: Accept/Decline _____
Initial

For office use only:

Brilliant Distinction Number: _____ Brilliant Distinction Password: _____

Aspire Program Number: _____ Aspire Program Password: _____

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Medical/Health History

Name: _____ _____
(First) (Last)

Date of Birth_____/ _____/ _____ **Current Age** _____

Do you have any of the following? Check all that apply:

___ Acne	___ Headaches	___ Pregnant or attempting
___ AIDS/HIV	___ Hearing problems	___ Radiation treatment
___ Anemia	___ Heart problems	___ Respiratory Disorder(s)
___ Anxiety problems	___ Hepatitis	___ Rheumatic Fever
___ Arthritis	___ Herpes Simplex	___ Rosacea
___ Asthma	___ Hiatal Hernia	___ Seizure disorders
___ Bell's Palsy	___ High/low blood pressure	___ Shingles
___ Bleeding disorder	___ Hypertrophic/Keloid scarring	___ Shortness of breath
___ Breastfeeding	___ Kidney disease	___ Sinus problems
___ Chronic fatigue	___ Lupus	___ Skin disease
___ Cirrhosis	___ Melasma	___ Stroke
___ Cold sores	___ Menopause (natural/surgical)	___ Substance abuse
___ Defibrillator implant	___ Mental illness	___ Syphilis
___ Depression	___ Metal implants	___ Thyroid Disorder high/low
___ Diabetes	___ Mitral Valve Prolapse	___ Tonsillitis
___ Eating disorder	___ Multiple Sclerosis	___ Tuberculosis
___ Emphysema	___ Myasthenia Gravis	___ Ulcers
___ Epilepsy	___ Pacemaker	___ Vision problems
___ Fibromyalgia	___ Permanent makeup tattoos	___ Weight gain/loss

Interviewer notes:

_____

_____

_____

Attach additional pages, if necessary

Are you allergic to any medications/products (including latex)? **Circle one:** Yes/No. If yes, please specify:

_____

_____

List any medications/dietary supplements you are currently taking (include **aspirin** or other **anti-coagulants** if applicable):

_____

_____

_____

Do you smoke? **Circle one:** Yes / No. If **yes**, how many cigarettes do you smoke per day? _____

Do you consume alcohol? **Circle one:** Yes / No. If **yes**, how much alcohol do you consume? _____

Have you experienced any recent "life-stressors": i.e. death in the family, divorce, job loss, etc.? If **yes**, please explain:

_____

Are there any other health/lifestyle concerns/conditions that could impact your treatment? If **yes**, please explain:

_____

Prior Treatments
Have you ever had any cosmetic injections/treatments before: If **yes**, what type of treatment and specify the location on face where treatment occurred.

_____

If you had cosmetic injections/treatment before, were you satisfied/not satisfied with your results? If **not satisfied**, please explain:_____

_____

Please share any specific concerns you might have had about prior treatments (i.e. drooping eyelids, ptosis from Botox)

_____

Treatment
What is the outcome you hope to achieve with ForeverYou?

_____

Please read and initial your affirmation to the following:

_____ I understand the information on this form is essential to determine my medical and cosmetic needs and formulate treatment plan.
_____ I understand that if any changes occur in my medical health, I will report them to ForeverYou prior to my next treatment.
_____ If I experience any adverse reactions possibly related to the treatment I received, I will report it immediately to ForeverYou.
_____ I have answered all the questions in this form truthfully to the best of my knowledge and will not hold ForeverYou or any agent of the corporation responsible for any errors or omissions that I have made in the completion of this form.
_____ I have read and understand the above medical health questionnaire.

Patient Signature **Date:**

_____ _____/_____/_____

For office use only
I have reviewed the above patient history.

Signatures: **Date:**

_____ _____/_____/_____
Treatment Specialist

_____ _____/_____/_____
Medical Director

ForeverYou

An Aesthetic Medical Corporation

Informed Consent

Patient Expectation

ForeverYou offers non-surgical alternatives to traditional cosmetic surgical interventions. While most clients of ForeverYou report positive results, these accounts can not be used to guaranteed favorable results for every individual. Since results cannot be guaranteed, no representation can or has been made as to the specific results of cosmetic injections. Additionally, no guarantee can or has been made or implied as to the "percent of improvement" you will receive treatment from ForeverYou. I understand, therefore, that the results of my procedure may be different from what I expect.

I also understand that it is not possible to predict my bodies reaction to treatment. I realize that there is a possibility of skin irritation and a potential for infection, allergic reaction, local irritation, or localized swelling with cosmetic injection procedure. This is a risk I am willing to accept. Also, I agree to notify ForeverYou or a health professional in case any of these complications occur.

Pre-care expectation

I agree and consent to being medically cleared for treatment by a nurse or doctor representing ForeverYou either in person or via some electronic medium.

Follow-up care

I agree to follow post-treatment instructions which may include a follow-up appointment(s) if necessary.

Patient Confidentially

Your health information is confidential and will never be given to anyone outside of ForeverYou. HIPPA privacy rules grants you certain rights, among them are a right to confidentiality, access to patient records, and obtaining copies of your records. For more information on your rights under HIPPA, go to http://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/.

Correspondence with ForeverYou

Unfortunately, we cannot guarantee the security of any communication originating from this office; yet, communication is critical for scheduling and treatment or health-related information. By initialing here _____ you agree to be contacted via email/text messages/phone call regarding your upcoming specials, appointments, or health-related information.

Refund policy

There is no refund for payment made for treatment. However, if you are not satisfied with you results, please contact ForeverYou for corrective options.

By signing and initially below, you affirm that you have read the above Informed Consent form agree to its terms and conditions.

_____

Patient name (please print)

_____ _____/_____/_____

Patient's signature Date

_____ _____/_____/_____

Witness Date

[Final document to be given to patient at the clinic]