



INTRADERMAL FILLER INJECTION CONSENT

To the CLIENT: You have a right to be informed about your condition and its treatment, so that you may decide 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 make you better informed so you may give, or withhold, your consent for treatment.

1. I, _____ understand that I am going to be injected with a dermal filler in the facial area. These injections are implanted intradermally through a fine gauge needle into the desired area.
2. Dermal fillers have been approved by the FDA for use in cosmetic treatments of fine facial wrinkles and I further understand it will be my physician or their designated staff member's decision in regards to which product will be used to treat me.
3. I understand that multiple treatments may be necessary to achieve desired results. Treatments generally last for up to 6 months or longer. Touch up treatments may be necessary to maintain desired results. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment. No refunds will be given for treatments received.
4. Possible Side Effects can include but are not limited to: Allergic reaction or infection, bleeding, tenderness or pain, redness, bruising, scarring, lumps, bumps or swelling at injection site.
5. People with a history of cold sores may experience a recurrence after the treatment, although this can be minimized by the use of antiviral medicines. I agree to consult with my physician if I have a history of cold sore or fever blisters prior to this treatment.
6. I have advised Spa in the City if I have severe allergies, particularly allergies to bacterial proteins. If I have an allergy to bacterial proteins I understand I am not a candidate for this treatment.
7. I have advised Spa in the City if I am pregnant, trying to get pregnant or if I am nursing.

I understand and agree that all services rendered to me are charged to me directly and that I am personally responsible for payment.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

Client Acknowledgement Regarding Spa In The City

1. Spa In The City LLC is owned and operated by Josanne Stephens. Spa In The City LLC is a lessee of Vernon & Waldrep OB-GYN Associates. Vernon & Waldrep OB-GYN Associates has no ownership interest, managerial oversight, or controls of the day-to-day business operations of Spa In The City LLC.

2. Josanne Stephens is not a physician nor holds herself out as a physician.

3. For certain services provided by Spa In The City LLC, such as the administration of Botox, a physician with Vernon & Waldrep OB-GYN Associates will assess the client prior to undergoing Botox treatment. Botox is a medication that can only be prescribed by a physician. Some patients may possess a condition, illness or disease that makes the use of Botox contraindicated. If Botox is contraindicated on that patient, they will not be permitted to receive Botox injections. The decision to permit the use of Botox is at the sole discretion of a physician with Vernon & Waldrep OB-GYN Associates. If a client has a medical problem associated with the injection of Botox, a physician with Vernon & Waldrep OB-GYN Associates will evaluate the patient and treat the patient as medically indicated. Physicians of Vernon & Waldrep OB-GYN Associates are paid by Spa In The City LLC for this medical review. This review does constitute a physician-patient relationship for this limited purpose.

4. Dr. Kim Vernon is the Medical Director of Spa In The City LLC. As Medical Director, Dr. Vernon exercises complete control over any and all medical decisions associated with Spa In The City LLC. Spa In The City LLC pays Dr. Kim Vernon for her services as Medical Director.

I have been given the opportunity to review this document, ask questions regarding the document and have had all my questions answered to my satisfaction. I have read and understand the above acknowledgement. **Initials:** _____

I release Dr Kim Vernon, Spa in the City and any or all technicians from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

Signature: _____ **Date:** _____



Intradermal Filler Aftercare

Some visible lumps may occur temporarily following the treatment.

You could experience increased bruising or bleeding at the injection site if you are taking fish oils, aspirin or other non-steroidal anti-inflammatory drugs such as ibuprofen. These reactions generally lessen or disappear within a few days but may last for a week or longer. Unless prescribed by your doctor, it is recommended you avoid these medications for several days after your treatment.

Arnica tablets should be taken and continued on the day of injections and a few days after. Arnica also comes in a gel form that may be used in addition to the tablets.

If there is swelling, you may place an ice pack over the swollen area.

Do not rub the injection site for 24 hours after injections.

People with a history of cold sores may experience a recurrence after the treatment, although this can be minimized by the use of antiviral medicines.

If you have questions or concerns please call 972-998-6484



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NEW PATIENT PERSONAL INFORMATION

Please complete the following:

Date: _____

Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Email Address: _____

Contact Phone: _____ Age: _____ Vernon & Waldrep patient? _____

How were you referred? _____ Have you had Botox before? _____

For our female clients: Are you pregnant or nursing? SSSSSS Using contraception SSSSSS

Please list all allergies (including medications, food, latex, cosmetics, lidocaine, sulfa, etc.) _____

Please list all medications, including herbal (esp. St John's Wort or Fish Oils) _____

List all operations (including plastic/laser procedures), hospitalizations, and any serious illnesses: _____

What are your concerns (please circle any of the following): unwanted hair, brown/red spots, wrinkles, lines, sagging skin, acne, blemishes, large pores, age spots, spider veins, scars, other (please list): _____

Please check all that apply: ___insulin dependent diabetes ___high blood pressure ___cancer ___stroke ___blood clots ___bleeding problems with cuts or surgery ___jaundice or hepatitis ___very dry skin ___thyroid disease ___active skin disease or lesions ___dizziness, palpitations or fainting spells ___cold sores or fever blisters ___psychiatric disorder ___hormone imbalance ___herpes ___HIV/Aids ___scars/Keloids ___active infection ___vitiligo, scleroderma, lupus, hives ___unwanted tattoos or permanent makeup ___other

Please elaborate on checked items: _____

Are you currently under the care of a physician? _____

Personal Physician: _____ Phone #: _____

SKIP TO SIGNATURE IF NOT HAVING LASER

PLEASE COMPLETE THE FOLLOWING IF HAVING LASER TREATMENTS

Which of the following best describes your skin type after 1 hour of unprotected sun exposure? (please circle one skin type #)

- I Always burns, never tans
- II Always burns, sometimes tans
- III Sometimes burns, always tans
- IV Rarely burns, always tans
- V Brown, moderately pigmented skin
- VI Black skin

Do you have a history of erythema (Abigne) which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irradiation? _____

Have you ever used Accutane, when? _____

What topical medications or creams are you currently using? Retin-A, Renova, Rentinol? (others please list) _____

Have you used any of the following hair removal methods in the past 6 weeks? ___ shaving ___ waxing ___ electrolysis ___ tweezing ___ threading ___ plucking ___ depilatories

Have you had any recent tanning or tanning products that changed the color of your skin? _____

Do you form thick or raised scars from cuts, surgeries or burns? _____

Check any of the following medications you have taken in the last 6 months (as they may increase hair growth or may be contraindications for laser treatments): ___ birth control pills ___ androgens (Rogaine) ___ Penicillin ___ cyclosporins ___ Minoxidil ___ steroids ___ Haldol ___ Phenytoin ___ thyroid medications ___ St John's Wort ___ Accutane ___ Tetracycline

SIGNATURE

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, doctor or nurse of my current medical or health conditions and to update this history as a current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature: _____ Date: _____

I have (circle one) reviewed the medical history or reviewed the medical history and conferred with the patient. I believe there are no contraindications to the planned aesthetic procedure.

Physician Signature: _____ Date: _____

SPA IN THE CITY

Notice of Privacy Practices

Effective Date: August 1, 2011

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Protecting your privacy and maintaining the security of your protected health information is one of the most important responsibilities of this office.

If you have any questions about this notice, please contact our **Privacy Officer**.

Our Obligations

We are required by law to:

- Maintain the privacy of protected health information, hereinafter designated "PHI".
- Give you this notice of our legal duties and privacy practices regarding your PHI.
- Follow the terms of our notice that is currently in effect.

How We May Use and Disclose Health Information

Except for the following, we will use and disclose health information only with your written permission:

- Treatment – We may use and disclose PHI for your treatment and to provide you with treatment-related services. For example, we may disclose PHI to doctors, nurses, technicians, pharmacists, including personnel outside our office who are involved in your care and need to provide you with care.
- Payment - We may use and disclose PHI so that we or others may bill and receive payment from you, from an insurance company, or a third party for the treatment and services you received.
- Operations – We may use and disclose PHI for operational purposes. These uses and disclosures are necessary to make sure that all of our clients receive quality care, and to operate and manage our office. For example, your PHI may be shared with quality improvement personnel to evaluate the performance of our staff.
- Appointment Reminders - We may use and disclose PHI to contact you and remind you of your appointment with us.
- Individuals Involved in Your Care or Payment for Your Care - We may use and disclose PHI with a person involved in your care such as your family or a close friend.
- Research - We may use your PHI for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI has approved the research.

Special Situations

- As Required by Law - We may disclose PHI when required to do so by international, federal, state, or local law.
- To Avert a Serious Threat to Health or Safety - We may disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

SPA IN THE CITY
Notice of Privacy Practices
Effective 8/1/2011

- Business Associates - We may disclose PHI to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of your PHI and are not allowed to disclose any information other than as specified in our contract.
- Lawsuits and Disputes – We may disclose PHI in response to a court order or subpoena only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- Law Enforcement - We may release PHI if requested by law enforcement official if the information is in response to a court order, subpoena, warrant, or summons.

Your Rights

You have the following rights regarding your protected health information (“PHI”):

- Right to Inspect and Copy – your medical and billing records. You must make this request in writing.
- Right to Amend – you may ask to amend the information when the information is in our office.
- Right to Accounting of Disclosures – you have the right to request a list of certain disclosures we made of your PHI other than for treatment, payment, operations, or disclosures with your written authorization. You must make this request in writing.
- Right to Request Restrictions – you have the right to request a restriction or limitation on the PHI we disclose for purposes of treatment, payment, operations, or to someone involved in your care or the payment of your care, like a family member or friend. For example, you may request that we not share information about a particular treatment with your spouse. This request must be made in writing. We are not required to agree to your request.
- Right to Request Confidential Communications - you have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. Your request must be in writing and must specify how or where you wish to be contacted. We will accommodate reasonable requests.
- Right to a Paper Copy of This Notice - You may ask us to provide you with a copy of this notice at any time.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to PHI we already have as well as any information we receive in the future. This notice will contain the effective date on the top of the first page.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the Department of Health and Human Services, 200 Independence Ave., SW, Washington, DC 20201. A complaint must be filed within 180 days of when the complainant knew or should have known that the act or omission complained of occurred. Filing a complaint will not interfere with your health care at this practice.



SPA IN THE CITY, LLC

7777 Forest Lane, Bldg D, Suite 570
Dallas, TX 75230

**Request for Limitations and Restrictions of
Protected Health Information “PHI”**

Note: We are not required to agree to your request. Please see our notice of privacy practices for more information regarding such requests.

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Type of PHI to be restricted or limited: (please check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Home Phone | <input type="checkbox"/> Home Address | <input type="checkbox"/> Occupation |
| <input type="checkbox"/> Name of Employer | <input type="checkbox"/> Visit notes | <input type="checkbox"/> Cell Phone |
| <input type="checkbox"/> Patient History | <input type="checkbox"/> Office Address | <input type="checkbox"/> Office phone # |
| <input type="checkbox"/> Spouse’s name | <input type="checkbox"/> Spouse’s office phone | <input type="checkbox"/> Email Address |
| <input type="checkbox"/> Other: _____ | | |

Please explain your restrictions – be specific.
How would you like use and/or disclosure of your PHI restricted? _____

Signature of Patient Date

Original – file in patient chart



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Dallas, TX 75230
(972) 998-6484

**Receipt of Notice of Privacy Practices
Written Acknowledgement Form**

Specifically for SPA IN THE CITY Clients

I, _____, have received a copy

of the privacy practices of SPA IN THE CITY.

Signature

Date