GracePointe Healthcare PLLC
Modern medicine the old fashioned way

PLEASE PRINT AND COMPLETE IN FULL **BOTOX PAPERWORK**

Date:_____

Name:_____ Nickname:_____
Last First M

Sex: Male____Female____ Birthdate:_____Age:_____ Social Security#:_____

If Patient is a minor, Parent / Guardian's Name:_____

Patient's Street Address:_____

City, State, Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address:_____

Emergency Contact Name and Phone Number:_____

Patient's Marital Status: Married___ Single____ Spouse Name_____

How did you hear about us? Supertalk 99.7_____ Friend/Family_____ Internet_____ Groupon____

Television____ Networking Event____ Other (Please Specify)_____

Reasons for visit (please be specific):_____

_____

_____

How will you pay today? Cash_____Check_____Credit Card_____ HSA/FSA Card _____

I understand payment in full is due at time of service.

I understand that a 24 hour notice is required for appointment cancellations and I will be charged a $49 fee if I fail to make my appointment without canceling at least 24 hours in advance.

Patient (or legal guardian) Signature_____

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Botox Medical History

Date of Visit:_____

Name:_____ Date of Birth:____/____/_____

Please list all medications your are currently taking:

_____

_____

Allergies to medication: _____

Please circle any of the following illnesses you currently have or have had in the past.

Myasthenia Gravis Hepatitis Eye Disease Autoimmune Disease Vision Problems

Numbness Muscle Weakness Multiple Sclerosis Amyotrophic Lateral Sclerosis (ALS)

Parkinson's Disease Neurological Disorders Lambert-Eaton Syndrome

List and/or explain other medical conditions not listed above:_____

_____

Previous Hospitalizations/Operations:_____

_____

Women: Are you pregnant, trying to get pregnant, or lactating/nursing? _____

Have you had Plastic Surgery or other surgery to your face/neck areas? When? _____

_____

Any previous Botox injections? _____ Last treatment?_____ What areas? _____

Were you happy with your previous botox treatments? Why or why not? _____

_____

Have you ever had eyelid/eyebrow droop after Botox?_____

Do you show a lot of upper eyelid when eyes are open?_____

Do your eyelids feel extra heavy when you don't get enough sleep?_____

Do your eyelids droop without sleep?_____

Areas of special concern to patient?_____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

_____ _____

Patient Signature Date

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1311 West Main Street
Franklin, TN 37064
(615) 599-6868 Fax: (615) 599-6988

Edward C. Leichner, D.O. Jennifer Heinrich PA-C Robert M. Tomsett Jr., PA-C Retha Thomas, FNP-BC

Informed Consent for Botulinum Toxin Injection (Botox from Allergan)

Botox is the botulinum toxin and works by paralyzing nerves and muscles. I, _____, consent to and authorize for the provider at GracePointe Healthcare to perform a treatment of facial wrinkles for Botox. Patient Initials _____

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. Patient Initials _____

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

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. Patient Initials _____
Known complications may include:
Redness, swelling/edema, itching, pain or pressure lasting more than one week

Porr effectiveness or allergic reactions	Will be 3-7 days before effects are apparent
Periodic treatment is necessary to maintain effects	Bruising and/or facial asymmetry
Paralysis leading to droopy eyelid or double vision	Nodules or induration at injection site
Discoloration at the injection site	Possible building of antibodies to Botox
The effects usually last 3-6 months	Weakness or flu-like symptoms

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

I also have none of the know conditions that would contraindicate treatment with botox such as; hypertrophy scars, autoimmune disease, or immune therapy. I am not pregnant or breastfeeding and I have no known allergy to Botox. Patient Initials _____

I have read this entire informed consent document. I agree to and understand this information. I am a competent adult of at least 18 years of age. My consent is given freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns. I agree that any pictures taken of my treatment and/or results may be used for publication and teaching purposes, however, my name will not be disclosed and complete confidentiality of my name will be maintained. Patient Initials _____

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

I understand that results are of a temporary nature and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions as state below: Patient Initials _____

No lying down or reclining for 4 hours after injection No scratching or rubbing the injected area
No bending forward for 4 hours No make-up applied to treated areas for 2 hours after injection

_____ _____
Patient Name Signature

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Botox/Filler Pre-Treatment Instructions

Botox/Filler

- To reduce risk of bleeding and bruising, avoid the following for 2 days prior to treatment:
  - Alcoholic beverages
  - Anti-inflammatories
  - Aspirin
  - Vitamin E
  - Ginkgo Biloba
  - Fish oil
- If you have a history of oral herpes simplex, you should be pre-treated prior to any lip enhancement procedure.

Botox/Filler Post-Treatment Instructions

Botox

- Effects are not immediate. You should see results in 3-7 days.
- Remain upright, no bending over or reclining for 4 hours.
- Do not massage or scratch the injection sites.
- Avoid make-up for 2 hours after injection.
- Exercise the treated muscles every 15 minutes for the next 4-6 hours.

Filler

- You may apply ice as needed to reduce swelling for the next 8 hours.
- Gently massage any nodules that may appear during the next 24 hours.
- Avoid prolonged sun or UV exposure for 2 weeks.
- Avoid saunas and steam baths for 2 weeks.
- Avoid make-up for four hours

Please note: Botox and Filler generally require two separate appointments at least one week apart to give the Botox time to fully take effect. If you desire to have both administered during the same appointment, you will need to speak with your healthcare provider in advance.

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Dr. Edward C. Leichner, D.O.
Robert M. Tomsett Jr., PA-C
Retha Thomas, FNP-BC
Jennifer Heinrich, PA-C

I understand I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow up among the multiple healthcare provider's who may be involved in that treatment directly and indirectly.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Patient Name: _____

If Guardian; Relationship to Patient: _____

Patient / Guardian Signature: _____

Today's Date: _____

……

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

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RELEASE AND ASSIGNMENT

I understand that in certain situations payment for services may not occur at the conclusion of my visit or in other cases, such as pathology services, GracePointe Healthcare may have to bill me for additional costs after my visit and that I am responsible for payment of all services rendered. I will pay all collection fees, court costs, attorney fees, and any other expenses required to reimburse GracePointe Healthcare, for services rendered.

Patient / Guardian Signature: _____ Date: _____

.....

I understand that GracePointe Healthcare uses automated appointment reminders that send emails, phone calls, and/or texts to remind me of my scheduled appointment. I consent to receiving these reminders and understand I can opt out at any time.

Patient / Guardian Signature: _____ Date: _____

.....

I understand that the office staff of GracePointe Healthcare may need to reach me via telephone. In the event I am unavailable, I authorize the office staff of GracePointe Healthcare to leave a message on my voicemail requesting a return call.

Patient / Guardian Signature: _____ Date: _____

.....

The office staff of GracePointe Healthcare may discuss my health care with the following individuals:

_____ _____
Name Phone Number / Relationship

_____ _____
Name Phone Number / Relationship

_____ _____
Name_____ Phone Number / Relationship _____

Patient / Guardian Signature:_____ Date: _____