Pre-Treatment Evaluation Form

Name:____ Date:________________

Medical History:____

Dates of any surgeries including cosmetic:____

Current Medications:____

Facial Medications:____

Drug, Contact, Food Allergies:____

Pregnant or planning to be pregnant:____

Have you received a skin exam with a dermatologist in the last year? Yes____ No____
Do you smoke? Yes____ No____ Do you drink? Yes____ No____
Any previous peels, microdermabrasion, laser treatments? Yes____ No____ Last Treatment _____________
Wax, pluck, shave, bleach, trim, electrolysis for unwanted hair? Area____________ Last Exposure_________
Have you ever taken Accutane? Yes____ No____ If so, when___________________________
Any history of herpes, hives, cold sores, fever blisters, or shingles? Yes____ No_____ Last Exposure___________
Any history of keloids (abnormal scarring) Yes____ No____
Do you suntan? Yes____ No_____ Do you use self-tanning lotions? Yes____ No____
Do you use sunscreen every day? Yes _____ No_____ What SPF____________
Have you ever had: Botox_____ Collagen injections______ Date_____________

Perm Make Up Tattoo: Yes ______ No _______ Location/Site: __________________________

What is your current skin care regimen including cleansers, toners, moisturizers, scrubs, facial masks, etc.?

____

____

SKIN TYPE**:**
Normal_____ Oily _____ Combination _____ Dry _____ Sensitive_____ Rough_____

What areas would you like to improve upon?

____

____

____

Office use only:
Benefits of procedure discussed: Yes_____ No_____ Contraindications reviewed: Yes_____ No_____
Risks reviewed: Yes_____ No_____ Probability of success: Yes____ No____
Patient going to proceed with: LHR ________ IPL_______ VBeam _______ Isolaz ______ MDA_______ Peels_______
Sublative ______ C+B ________ HF _______

Services Suggested:____

Products Suggested:____

Signature of consultant:____

COSMETIC PATIENT REGISTRATION

(Office Use) Patient Account #_______________

Please PRINT Clearly **Today's Date:**________________

PATIENT:

How did you hear about us? □ Yellow Pages □ Physician □ Friend
□ The News Journal □ Delaware Today □ Other___________________

Title: □ Mr. □ Ms. □ Family

Name:____
(Last) (First) (Middle)

Address:____
(Street) (City) (State)
(Zip)

DOB:_____________ **Gender:** □ Male □ Female **E-Mail:**_____________________

Status: □ Single □Married □ Other

Phone:___________________ **Phone:**__________________ **Phone:**__________________
(Home) **(Work)**
(Cell/Mobile)

Patient's Occupation:____

Person to Contact in Case of Emergency:____

Phone:_____________________

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Thank you for choosing PREMIER SPA & LASER CENTER for your aesthetic needs.

Please be advised that our services are elective cosmetic procedures, the care provided at Premier Spa & Laser Center is not covered by any medical insurance programs and we do not participate in any such plans. Payment is required at the time of your treatment. For specially packaged treatments, payment for the entire package is due at the time of the first scheduled treatment.

Please read and sign our financial and etiquette policy below to verify your receipt and understanding of this information.

1. For the comfort of all our guests, please reduce or mute the volume on your cell phones, laptops and pagers.
2. Please refrain from inappropriate language or actions. If this does occur your aesthetic provider may terminate your service, without a refund.
3. For safety reasons, the maximum occupancy of each spa room is two people. Anyone accompanying you to your spa visit is welcomed to wait in the waiting room.
4. Children under 12 may not be left unattended; you may need to reschedule your appointment should your children come with you to the spa.
5. We provide a number of payment options which may be used individually or combined according to your desires. Cash, check, Visa, and MasterCard are accepted.
6. Returned checks are subject to a $30.00 service charge.
7. We understand that a situation may arise that could force you to cancel or postpone your treatment. Please understand that such changes affect not only our staff but our other patients as well, and we therefore request your courtesy and concern. If you need to cancel your appointment, **please allow 24 hours to notify us of the cancellation**.
8. Missed appointments or same day cancellations will be subject to a $30.00 missed appointment fee. We understand that emergency situations do arise and we will accommodate you if at all possible.
9. **Clients arriving ten minutes** after their scheduled appointment time will be considered late for their appointment, and their appointment may be rescheduled as a result, allowing the provider to take their next scheduled appointment on time.
10. If a client **no shows or cancels** with less than 24 hours' notice **3 times within a 12-month time period,** any future appointments can only be scheduled if the appointment is pre-paid at the time of scheduling.
11. Every effort is made to accommodate your request to see specific providers but we cannot guarantee that you see the same provider for all treatments. We will inform you of these changes prior to treatment.
12. For all Coolsculpting treatments and appointments exceeding one hour, a 10% deposit is required at the time of scheduling the appointment. This deposit will be forfeited, if a cancellation less than 24 hours occurs or the appointment is missed.
13. Skin care product purchases can be returned within 30 days of purchase. <u>Latisse, Renova, Retin A and Hydroquinone products cannot be returned</u>. All Clarisonic product returns or problems must be done through L'Oreal/Clarisonic. We can provide you the necessary receipt to assist with your return. A refund by Premier Spa & Laser Center may not be provided in the same form of initial payment(s). All refunds will be provided by a check in the mail within 2-3 weeks of receipt of return. If you do not wish a check refund a credit can be left on your account for future service(s) and/or purchase(s) within the spa.
14. Gratuities are appreciated for several of our spa services such as waxing, spray tanning etc. Only cash gratuities can be accepted.
15. Your credit card information may be stored by our client management partner Transaction Express. With your consent we reserve the right to use the stored credit card information to pay for continuing or recurring service, no show/late arrival fees and outstanding balances on the client's account.

These policies are subject to change without notice. If you have any questions or need assistance with any financial matters relating to your treatment, please contact our Aesthetic Associates for help.

X____DATE:________________MRN:___________

PATIENT, GUARANTOR, OR PERSONAL REPRESENTATIVE'S SIGNATURE

The patient/guarantor has the responsibility to inform PSLC if the patient's contact information changes, i.e. phone number, address, and email. Your signature on this page signifies that you acknowledge and accept the above information.

TREATMENT CONSIDERATIONS FORM

The CoolSculpting® procedure is a non-invasive procedure that is intended to change the appearance of the treatment area by delivering controlled cooling at the surface of the skin to break down fat cells that are just beneath the skin. This procedure is not a treatment for obesity or a weight-loss solution. The CoolSculpting procedure does not replace traditional methods such as diet, exercise or liposuction. **Initial:** _____

Clinical studies of a treatment site have shown that the CoolSculpting procedure can break down fat cells to change the appearance of visibly localized bulges of fat that is just beneath the skin on the abdomen, thighs, flanks and submental area. The submental area is the area under the chin. Following the procedure, the treated fat cells are naturally processed by the body. Visible results can vary from person to person. **Initial:** _____

WHAT YOU CAN EXPECT:

Temporary Sensations / Symptoms:

» The suction pressure of a vacuum applicator may cause sensations of deep pulling, tugging and pinching. A surface applicator may cause sensations of pressure. You may experience intense cold, stinging, tingling, aching or cramping as the treatment begins. These sensations generally subside during treatment as the area becomes numb. **Initial:** _____

» You may have dizziness, lightheadedness, nausea, flushing, sweating, or fainting during or immediately after the treatment. **Initial:** _____

»The treated area may look or feel stiff after the procedure and transient blanching (temporary whitening of the skin) may occur. These are all normal reactions that typically resolve within a few minutes. **Initial:** _____

» Bruising, swelling, redness, cramping and pain can occur in the treated area and the treated area may appear red for one to two weeks after treatment. **Initial: _____**

» After submental area treatment, a feeling of fullness in the back of the throat may occur. Initial if the submental area is to be treated. If the area under the chin is not being treated, please write N/A. **Initial:** _____

» You may feel a dulling of sensation in the treated area that can last for several weeks after the procedure. Prolonged swelling, itching, tingling, numbness, tenderness to the touch, pain in the treated area, cramping, aching, bruising and/or skin sensitivity also have been reported. **Initial:** _____

Potential Side Effects / Risks

» Paradoxical Hyperplasia -- A small number of patients have experienced gradual development of a firmer enlargement, of varying size and shape, of the treatment area, known as "paradoxical hyperplasia", in the months following the treatment. If such paradoxical hyperplasia occurs, it will be distinguishable from temporary swelling and will probably not resolve on its own. The enlargement/lump can be removed by means of a surgical procedure such as liposuction. **Initial**: _______

» Treatment area demarcation -- A small number of patients have experienced excessive fat removal in the treatment area, resulting in an unwanted indentation. The indentation may be improved through corrective procedures. **Initial**: _______

» In rare cases, patients have reported the CoolSculpting treatment area to have darker skin color, hardness, discrete nodules, frostbite (local injury due to cold), hernia or worsening of pre-existing hernia. Surgical intervention may be required to correct hernia formation. **Initial**: _______

» Patient experiences may vary. Some patients may experience a delayed onset of the previously mentioned symptoms. Contact your physician immediately if any unusual side effects occur or if symptoms worsen over time. **Initial:** _____

» I understand that these and other unknown side effects may also occur. **Initial:** _____

Results

» You may start to see changes in as early as three weeks after your CoolSculpting procedure, and will experience the most dramatic results after one to three months. Your body will continue to naturally process the injured fat cells from your body for approximately four months after your procedure. **Initial:** _____

» Results vary from person to person. You may decide that additional treatments are necessary to achieve your desired outcome. Although highly unlikely, it is possible that you will not experience any noticeable result from the procedure. **Initial:** _____

Do you currently have or have had any of the following?

» Cryoglobulinemia (a condition in which an abnormal level of proteins thicken the blood in cold temperatures), or paroxysmal cold hemoglobinuria or cold agglutinin disease (blood disorders in which cold temperatures lead to red blood cell death). ……………………………………………………………………………………………**Yes / No**

» Known sensitivity to cold such as cold urticaria (hives triggered by cold), Raynaud's disease (disorder in which cold leads to reduced blood flow in the fingers, which appear white, red, or blue), pernio or Chilblains (itchy and/or tender red or purple bumps that occur as a reaction to cold). ………………………………………………………**Yes / No**

» Poor blood flow in the area to be treated……………………………………………………………………**Yes / No**

» Neuropathic (nerve) disorders such as post-herpetic neuralgia or diabetic neuropathy……………………………**Yes / No**

» Impaired skin sensation ……………………………………………………………………………………**Yes / No**

» Open or infected wounds ……………………………………………………………………………………**Yes / No**

» Bleeding disorders or use of blood thinners ……………………………………………………………**Yes / No**

» Recent surgery or scar tissue in the area to be treated………………………………………………**Yes / No**

» A hernia or history of hernia in the area to be treated or adjacent to treatment site …………………………**Yes / No**

» Skin conditions such as eczema, dermatitis, or rashes………………………………………………**Yes / No**

» Pregnancy or lactation (making breast milk or breast feeding) …………………………………………**Yes / No**

» Any active implanted devices such as pacemakers and defibrillators ……………………………………**Yes / No**

» Any major health problems such as liver disease ……………………………………………………**Yes / No**

» Any known sensitivity to isopropyl alcohol (rubbing alcohol) or propylene glycol ……………………………**Yes / No**

Pictures will be obtained for medical records. If pictures are used for education and marketing purposes, all identifying marks will be cropped or removed. **Initial:** _____

As with most medical procedures, there are risks and side effects. These have been explained to me in detail. I have read the above information, and I give my consent to be treated with the CoolSculpting® procedure by the physician(s) in this practice and his/her designated staff.

Print Name: ______________________ Signature:______________________ Date: __________

Witness: ______________________ Date: __________

Physician(s): ______________________ Practice Name: ______________________

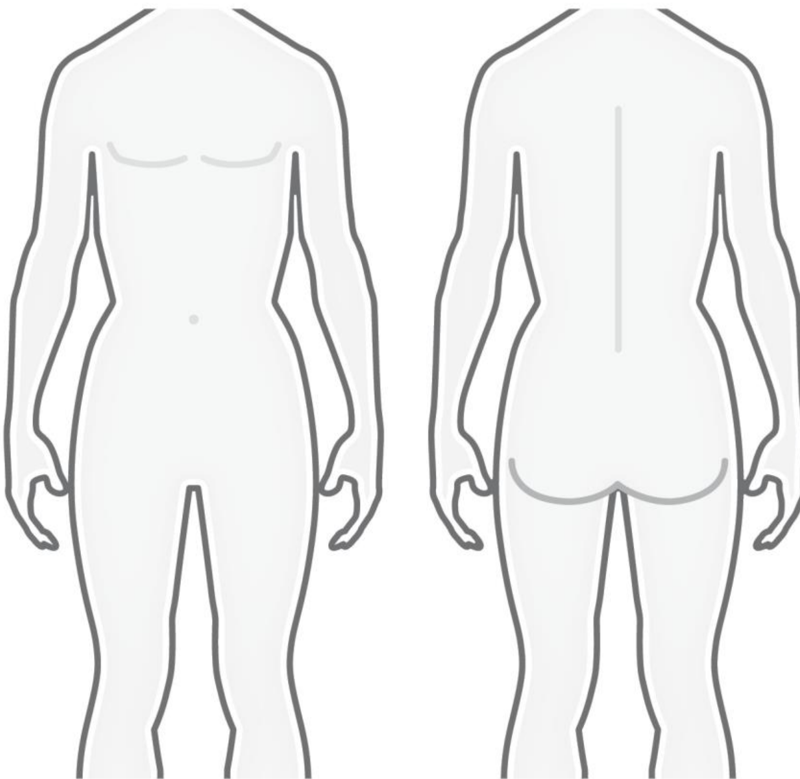
TREATMENT CONSULTATION FORM

Patient Name: ____ Date: ______________________________

Consultation led by: _______________________________ Gender: M / F Weight ____________________

Has your patient had other aesthetic procedures for the body? ____

How did your patient hear about CoolSculpting? ____



TREATMENT PLAN

CoolCurve+ (or eZ App 6.2): ______

CoolCore (eZ App 6.3): __________

CoolFit: ____________________

CoolMax (eZ App 8): ___________

Total: ____________________

PRICING

Treatment price: ______________

Discount: __________________

Total: ____________________

Savings: ___________________

consultation day

Notes:

Patient Signature: ____ Date: __________________

Disclaimer: In the U.S. and Taiwan, non-invasive fat reduction is cleared only for the flank and abdomen.

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