

## Patient Information & Medical History

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Email Address: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_

Cellular: \_\_\_\_\_ Work: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

### Personal Medical History and Health

Do you have or have had any of these in the past year?

- Pneumonia
- Rheumatic Fever
- Heart disease
- Arthritis or Rheumatism
- Gonorrhea or Syphilis
- Anemia
- Jaundice
- Epilepsy/Convulsions
- Tuberculosis
- Diabetes
- Cancer
- High Blood Pressure
- Liver Disease
- Thyroid Disease
- Anxiety Disorder
- Glaucoma
- None

Any other medical condition

Explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ALLERGIES:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MEDICATIONS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Last Menstrual Cycle (LMP): \_\_\_\_\_

I certify that preceding medical and personal statements are true and correct. I am aware that it is my responsibility to inform the doctor of my current medical and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

FOR OFFICE USE ONLY

ID photo taken: \_\_\_\_\_

VN: \_\_\_\_\_

**Office Policy (Please initial each point acknowledging you understand that:**

\_\_\_\_\_ If you miss your appointment, you may be subject to a \$25 fee unless you call 24 hours in advance.

\_\_\_\_\_ Services must be paid for at the time of service.

\_\_\_\_\_ Health insurance typically does not cover services provided. If you want to seek insurance reimbursement, we would be happy to provide you itemized invoices that you can submit to your insurance company.

\_\_\_\_\_ Phentermine and Vyvanse are considered a controlled substance. I agree that I will take my medications as prescribed. I agree to follow my medical providers instructions. I also agree that I will not sell or share my prescriptions to other individuals. I understand that practice is not responsible for lost script.

\_\_\_\_\_ I understand that treatments used might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life through hormone restoration, nutritional and supplemental counseling, and weight loss treatment.

\_\_\_\_\_ I agree that if I am having any side effects or become sick, that I will follow up with my primary care provider or go to an urgent care or emergency department. I acknowledge that Dr Motamedy is not my primary care provider. I agree that I will continue with routine care through my primary care provider and notify them of treatments prescribed.

\_\_\_\_\_ I understand that there are no refunds on shot packages purchased, services or products rendered. We cannot accept back used medications/ products once they have been dispensed per state regulation.

\_\_\_\_\_ I understand that having an appointment with us does not necessarily entitle me to being issued a prescription for hormone replacement, weight loss medication or additional medications. Every individual is different, and it is at the medical providers discretion to issue a prescription.

\_\_\_\_\_ I acknowledge that I have been advised of the risks and benefits of treatment. I also acknowledge that I have been advised of possible complications and side effects. I understand the risks, benefits, complications, and side effects of treatment.

\_\_\_\_\_ I am voluntarily requesting treatment with River Oaks/ Bellaire Beauty and Weight loss Center in regards to weight loss therapy as determined by a mutual decision between myself and the medical provider even if my hormone levels are considered to be in normal range for my age based off of other medical society recommendations and guidelines or if I am just considered overweight and not obese.

**I have read, understand, and agree to all the above statements.**

Print Name: \_\_\_\_\_ Patient Signature ----- Date-----

## Consent for the use of Hyaluronic acid and Dermal fillers

I have read the information pertaining to Hyaluronic Acid procedure and hereby authorize Dr. Motamedy and/or River Oaks Weight Loss Center/Bellaire Weight Loss Center to use Hyaluronic Acid dermal fillers on face and/or body. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained from the use of hyaluronic acid dermal fillers. I consent to photo graphic use for medical, advertising and/or educational purposes for the appropriate portions of the face and/or body. I am aware that there are risk to hyaluronic acid injections that future research may discover.

**RISK OF FILLER INJECTIONS:** Every procedure involves a certain amount of risk and it is important that you understand these risks and the possible complications associated with them. In addition, every procedure has limitations. An individual's choice to undergo this procedure is based on the comparison of the risk to potential benefit. Although the majority of patients do not experience the following, you should discuss each of them with your physician to make understand the risks, potential complications, limitations, and consequences of facial filler injections. Problems associated with the use of tissue fillers can relate to normal occurrences following tissue filler injections, or potential complications following tissue filler injections.

### Normal Occurrences During Tissue Filler Injections

**Bleeding and Bruising:** It is possible, though unusual, to have a bleeding episode from a filler injection or local anesthesia used during the procedure. Bruising in soft tissue may occur. Should you develop post-injection bleeding, it may require emergency treatment or surgery.

Aspirin, anti-inflammatory medications, platelet inhibitors, anticoagulants, Vitamin E, ginkgo biloba and other "herbs/homeopathic remedies" may contribute to a greater risk of bleeding problem. Do not take any of these for seven days before or after filler injections.

**Swelling:** Swelling (edema) is a normal occurrence following the injections. It decreased after a few days. If swelling is slow to resolve, medical treatment may be necessary.

**Pain:** Discomfort associated with injections is normal and usually of short duration.

**Specific Risks of Filler Injections Needle Marks:** Visible needle marks from the injections occur normally and resolve in a few days.

Initial \_\_\_\_\_

## INFORMED CONSENT – FACIAL FILLER INJECTION

**Erythema (Skin Redness):** Erythema in the skin occurs after injections. It can be present for a few days after the procedure.

**Under / Over Correction:** The injection of soft tissue fillers to correct wrinkles and soft tissue contour deficiencies may not achieve the desired outcome. The amount of correction may be inadequate or excessive. It may not be possible to control the process of injection of tissue fillers due to factors attributable to each patient's situation. If under correction occurs, you may be advised to consider additional injections of tissue filler materials.

**Asymmetry:** The human face is normally asymmetrical in its appearance and anatomy. It may not be possible to achieve or maintain exact symmetry with tissue filler injections. There can be a variation from one side to the other in terms of the response to injection. Addressing this may require additional injections.

**Damage to Deeper Structures:** Deeper structures such as nerves and blood vessels may be damaged during the course of injection. Injury to deeper structures may be temporary or permanent.

**Skin Lumpiness:** Lumpiness can occur following the injection of fillers. This tends to smooth out over time. In some situations, it may be possible to feel the injected tissue filler material for long periods of time.

**Visible Tissue Filler Material:** It may be possible to see any type of tissue filler material that was injected in areas where the skin is thin.

**Granulomas:** Painful masses in the skin and deeper tissues after a filler injection are extremely rare. Should these occur, additional treatments including surgery may be necessary. Fillers should not be used in areas with active inflammation or infections (e.g., cysts, pimples, rashes or hives).

**Migration of Filler:** The filler substance may migrate from its original injection site and produce visible fullness in adjacent tissue or other unintended effects.

**Skin Necrosis:** It is very unusual to experience death of skin and deeper soft tissues after injections. Skin necrosis can produce unacceptable scarring. Should this complication occur, additional treatments, or surgery may be necessary.

**Allergic Reactions and Hypersensitivity:** As with all biologic products, allergic and systemic anaphylactic reactions may occur. Fillers should not be used in patients with a history of multiple severe allergies, severe allergies manifested by a history of anaphylaxis, or allergies to gram-positive bacterial proteins. Allergic reactions may require additional treatment.

**Drug and Local Anesthetic Reactions:** There is the possibility that a systemic reaction could occur from either the local anesthetic or epinephrine used for sensory nerve block anesthesia when tissue filler injections are performed. This would include the possibility of light-headedness, rapid heartbeat (tachycardia), and fainting. Medical treatment of these conditions may be necessary.

**Antibodies to Fillers:** Presence of antibodies to hyaluronic acid tissue fillers may reduce the effectiveness of this material or produce a reaction in subsequent injections. The health significance of antibodies to hyaluronic acid tissue fillers and other fillers is unknown.

**Accidental Intra-Arterial Injection:** It is extremely rare that during the course of injection, fillers could be accidentally injected into arterial structures and produce a blockage of blood flow. This may produce skin necrosis in facial structures or damage blood flow to the eye, resulting in loss of vision. The risk and consequences of accidental intravascular injection of fillers is unknown and not predictable.

**Scarring:** Fillers should not be used in patients with known susceptibility to keloid formation or hypertrophic scarring. The safety of patients has not been studied.

**Unsatisfactory Result:** Filler injections alone may not produce an outcome that meets your expectations for improvement in wrinkles or soft tissue depressions. There is the possibility of a poor or inadequate response from filler injection(s). Additional injections may be necessary. Surgical procedures or other treatments may be recommended in addition to additional treatments.

Patient Initials

**Acne-Like Skin Eruptions:** Acneiform skin eruptions can occur following the injection of tissue fillers. This generally resolves within a few days.

**Skin Sensitivity:** Skin rash, itching, tenderness and swelling may occur following injections. After treatment, you should minimize exposure of the treated area to excessive sun or UV lamp exposure and extreme cold weather until any initial swelling or redness has gone away. If you are considering laser treatment, chemical skin peeling or any other procedure based on a skin response after filler treatment, or you have recently had such treatments and the skin has not healed completely, there is a possible risk of an inflammatory reaction at the implant site.

**Infection:** Although infection following injection of tissue fillers is unusual, bacterial, fungal, and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a tissue filler treatment. This applies to both individuals with a past history of Herpes simplex virus infections and individuals with no known history of Herpes simplex virus infections in the mouth area. Specific medications must be prescribed and taken both prior to and following the treatment procedure in order to suppress an infection from this virus. Should any type of skin infection occur, additional treatment including antibiotics may be necessary.

Initial. \_\_\_\_\_

I consent to the use of Hyaluronic acid dermal fillers and understand that Hyaluronic acid dermal fillers are used as inject-able fillers. All my questions have been answered to my satisfaction.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Patient/guardian signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

MD /Provider Signature: \_\_\_\_\_

**Photograph**

I authorize taking of photographs as part of cosmetic procedure policy and promotional use. **Initials:** \_\_\_\_\_

I consent to the use of Hyaluronic acid dermal fillers and understand that Hyaluronic acid dermal fillers are used as inject-able fillers. All my questions have been answered to my satisfaction.

\_\_\_\_\_  
Print Name

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Date

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Witness

MD/Provider Signature: \_\_\_\_\_