Ultimate Image
COSMETIC MEDICAL CENTER
Medically Directed Services Combined With Luxury

Name: _____ **Todays Date**:_____ **Date of Birth:** _____ **Sex:** M/F

Home Phone: ( ) _____ - _____ May we leave voice or text messages regarding appts? ☐Yes ☐No
Cell Phone: ( ) _____ - _____ May we leave voice or text messages regarding appts? ☐Yes ☐ No
Street Address: _____ **City**: _____ **State**: _____ **Zip**: _____
E-Mail: _____ _____ (we send discount notifications through email)

Emergency Contact: _____ **Cell Phone:** _____
Can we release information to your emergency contact? **Circle one:** Yes / No **Signature:** _____

Circle how you heard about Ultimate Image:
Website**/** Web search: Keyword: _____ Friend Referral (Name of Friend):_____
Magazine/Television/Groupon/Event:_____ Other:_____
Circle Skin Type: Fair Skin-Blonde**/**Fair Skin-Brunette**/**Average Skin**/**Olive Skin-Hispanic**/**Dark Skin-Middle East**/**Black
Circle If You have ever had: Keloid **/** Accutane **/** Cold Sores **/** Fever Blisters **/** Shingles **/** Herpes **/** HIV **/** Hepatitis **/** Fibromyalgia **/** Yeast **/** Headaches **/** Chronic Pain **/** Chronic Fatigue Syndrome **/**Epstein Barr **/**Depression **/** Anxiety **/** Bipolar **/** Irritable Bowel
List any other medical problems: _____
List current medications & supplements: _____
List current skin care products: _____
List all allergies: _____
List cosmetic procedures you have had:_____
What is your main Cosmetic Concern(s)? _____
Occupation: _____
Check which procedures you are interested in:
☐ **DUAL Fraxel 1550/1927 Treatments -** For brown spots, redness, wrinkles, acne scars, & firms the skin;
☐ **Botox** or **Dysport -** Relaxes brow, eye, & forehead wrinkles; ☐ **FILLER -** Fills lines around face; ☐ **PRP-** Platelet Rich Plasma; ☐ **ThermiTight Lipo-** Liposuction; ☐**Verju -** Cellulite & Body Sculpting; ☐ **Liposonix -** Non-Surgical Fat Removal; ☐ **Laser Hair Removal;** ☐ **Vein "Removal";** ☐ **Rx Weight Loss Program;**
☐ **Levulan & Blu-Light -** Reduces Acne; ☐ **Esthetician Services -** Facial, Peels, Microderm;
☐ **Minor Surgery -** Scar or mole removal

I acknowledge I received a copy of the Privacy Policy of Ultimate Image Cosmetic Medical Center. I am not pregnant or breast feeding. I realize that if I become pregnant, I should not have any cosmetic procedures and should stop using all medications and skin care products until I am given permission to use them by my Obstetrician. If I become pregnant I will notify Dr.Besnoff both in writing & verbally and cancel any appointment or procedure. **I have listed all of my current medical problems and medications on the patient information form**. If in the future I develop any new medical problems or start taking any new medications, I will inform Dr. Besnoff in writing & Verbally prior to any appointment or procedure. I understand that Dr. Besnoff cannot give me the proper treatment, nor be held responsible, if I do not disclose up to date information about my health. **I consent to have before/after treatment pictures and television filming of any and all procedures by Todd A. Besnoff, MD.** I give my permission for Dr. Besnoff to use the pictures and film for medical, educational and advertisement purposes. I realize that I will not be compensated for the use of the pictures.

Patient's Signature_____Patient's Printed Name_____Date_____

Witness's Signature_____Witness's Printed Name_____Date_____

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Esthetician Skin Evaluation & Consent Form

Facials, Microdermabrasions, Skin Peels, Waxing, & Make-up Application

Patient Name: _____ Date: _____

Your Skin Type is: ☐ Dry ☐ Normal/Combination ☐ Oily ☐ Acne Prone

Do you have or had history of any of the following: ☐Skin Disease/Cancer ☐ Cold Sores/Herpes on Face
☐ Skin Allergies ☐ Eczema ☐ Diabetes ☐ Rosacea ☐Active Acne ☐Keloids ☐ Smoking
☐ Other: _____

Have you ever experienced an allergic reaction or sensitivity to any medications, foods, or products? If so explain:
_____

What do you use to cleanse your face? ☐ Soap:_____ ☐Non-soap Cleanser: _____

Do you use a toner? ☐ Yes ☐ No Brand:_____

Do you use: ☐Retin-A ☐ Differin ☐ Azelex ☐ Renova ☐ Accutane
☐ Salicylic Acid Products ☐ Alpha Hydroxy Acid Products
If yes, when is the last time you used this? _____

What brands of cosmetic products do you currently use most? _____

Have you had previous esthetician or cosmetic medical treatments? If yes, what type and when?
_____
_____

Are you pregnant or actively trying to get pregnant? ☐ Yes ☐ No

Do you have any other areas you would like to treat? (Example: Hands, Neck, Chest, Etc.)
Please explain: _____

Do you go to tanning beds or have regular sun exposure? ☐Yes ☐No How Often? _____

Do you use sunscreen? ☐ Daily ☐ Occasional ☐ Only for outdoor use Face SPF #_____ Body SPF #_____

Please explain your daily skin care regimen: _____
_____

What are the cosmetic improvements you would like to see in your skin? _____
_____

Prior to treatment I have revealed any condition that may have bearing on this procedure. I understand there may be some discomfort. I understand that although complications are rare, sometimes they may occur, and in such event I will contact my esthetician immediately. I understand possible complications may include: scabbing, hyperpigmentation, broken blood vessels, and/or worsening of acne. I understand there are no guarantees as to results of this treatment and there are no medical claims expressed or implied. I understand to achieve maximum results I will need several treatments. I understand direct sun exposure is prohibited and sunblock of SPF 15 or greater is mandatory. By my signature below I understand I have read and understand the contents of this consent form and the disclosures referred to herein were made to me.

Patient Signature: _____ Patient Name: _____ Date: _____

Witness Signature: _____ Witness Name: _____ Date: _____

Information About Topical Anesthetics

Compound

Benzocaine 20%/ Lidocaine 10%/Tetracaine 4% in a gel or ointment base (compounded)

Use

This topical anesthetic is a compound used to prevent pain associated with various medical procedures. Because the preparation is compounded, it is not available commercially. It is therefore not an FDA approved product. The use of this product is solely at the discretion of the prescribing physician for the use of individual patients.

Side Effects

The following is a statement provided by the compound pharmacy. *"This preparation may cause local irritation in some individuals who are sensitive to the active ingredients. Either cool or warm sensation is common and does not necessarily indicate an allergic reaction. You may experience local numbness for a period of time which is temporary. Other, more serious side effects could occur when systemic absorption occurs. If you experience severe itching, marked redness, swelling at the site of application, blurred vision, nausea, dizziness, tremors, convulsions, respiratory problems, irregular heartbeat, or tinnitus consult your physician, pharmacist or health care practitioner immediately."*

Precautions

Do not use this product if you are sensitive to local anesthetics (Benzocaine, Lidocaine or Tetracaine). Use cautiously if allergic to Sulfa containing drugs or if you are allergic to PABA. Topical anesthetics should be used with extreme caution in the following patients: those taking antiarrhythmic, antiepileptic or antiseizure medications, cardiac patients, patients with compromised liver function, children, and the elderly. Neonatal use and use during pregnancy or while nursing is not recommended. This preparation is to be used topically only. Avoid contact with eyes. Use caution in handling the affected area by avoiding extreme heat or cold and over scratching the site of application. DO NOT use the product on large surface areas consisting of multiple body sections during a single procedure as systemic absorption could occur. A rare complication known as benzocaine-induced methemoglobinemia has been reported in the literature when Benzocaine containing products are swallowed or systemically absorbed. Please note that we are not aware of any scientific studies that have been performed for this combination of anesthetics. The use of this compound is therefore at the sole discretion of the prescribing physician. Use this product conservatively whenever possible.

I attest to understanding the above information and confirm that I do not have any of the medical history mentioned nor do I take any of the medications that would have an adverse effect with a topical anesthetic. Furthermore, I understand that there may be side effects to the use of the anesthetic as mentioned above.

Patient Name _____ Patient Signature _____

Date_____

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Refund, Payment, & Appointment Cancellation Policies

1. Refunds will not be given for services performed or products sold.

2. No refunds will be given for services that the patient cancels prior to the service being performed.

3. All services must be paid prior to the service being performed. If for any reason payment is not paid prior to the service being performed, payment will be made immediately after the procedure has been performed.

4. When a service or product is purchased it cannot be exchanged for another service or product.

5. If a patient fails to complete his or her services within one year of purchase the patient forfeits his or her money and no service is owed.

6. When a procedure is scheduled, staff and other resources are reserved for the designated date and time. Therefore, if a patient cancels a procedure without giving a 24 hour notice Ultimate Image may apply a $25.00 cancellation fee to the patient's next appointment.

7. In the event that the Payer fails to pay for said medical services immediately, Patient/Payer agrees to pay all fees, costs, reasonable attorney fees, interest and expenses incurred by Centre before trial, at trial, and/or on appeal.

8. Patient waives the right to stop payment of said check or cancel any charges on credit/debit card for the medical services provided or to be provided.

9. In the event that the Payer violates this agreement by stopping payment on said check or said check is returned as unpaid; and then Patient/Payer agrees to pay for those services directly to the Centre immediately. Patient also agrees to pay a $25.00 fee for any and all checks returned as unpaid.

I have read, understand, and have had all questions answered to my satisfaction regarding the above refund, payment and cancellation policies. My signature below indicates my agreement with the above refund, payment and appointment cancellation policies of Ultimate Image Cosmetic Medical Center.

Patient's Signature_____ Patient's Printed Name _____Date_____

Witness's Signature_____ Witness's Printed Name _____Date_____