Mesotherapy-Lipotherapy-Lipodissolve
Health Questionnaire

Patient Name_____ Date_____

Age_____ DOB_____ Height _____ Weight _____

Occupation: _____ ☐ Full time ☐ Part time ☐ Retired

What area of cosmetic improvement are you interested in? _____

ALLERGIES:

Conditions/ Medical History

Check ✓ conditions you currently have or had had in the past

☐ AIDS	☐ Open Heart Surgery/ CABG	☐ GERD	☐ Kidney Disease	☐ Parkinson's
☐ Alcoholism	☐ Cancer	☐ Glaucoma	☐ Liver Disease	☐ Prostate Problems
☐ Anemia	☐ Chronic Fatigue Syndrome	☐ Goiter	☐ Measles	☐ Psychiatric care
☐ Anorexia	☐ Chemical Dependency	☐ Gout	☐ Migraines	☐ Stroke
☐ Appendicitis	☐ Chicken Pox	☐ Heart Disease	☐ Miscarriage	☐ Suicide Attempts
☐ Arthritis	☐ Colitis/ Crohn's disease	☐ Hepatitis A B C	☐ Mononucleosis	☐ Tonsillitis
☐ Asthma	☐ Depression	☐ Hernia	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Bleeding Disorder	☐ Diabetes	☐ Herpes	☐ Mumps	☐ Ulcers
☐ Breast Lump	☐ Emphysema	☐ High Cholesterol	☐ Pace Maker	☐ Vaginal Infections
☐ Bronchitis	☐ Fibromyalgia	☐ HIV	☐ Pneumonia	☐ Venereal Disease
☐ Bulimia	☐ Epilepsy/ seizures	☐ Irritable Bowel Syndrome	☐ Polio	☐ Spleen surgery

HEATH HABITS:

Cigarettes/Cigars per day_____ How Long _____ Quit/When _____

Coffee: # of cups per day _____ Soda; # of cans per day _____

Water: # of glasses per day _____ Alcohol use: _____ Number/day _____

Exercise: ☐ 5-7 days per week ☐ 3-4 days per week ☐1-2 days per week

☐ 45 minutes or more duration per workout ☐ 30- 45 duration per workout ☐ less than 30 minutes

☐ Aerobics ☐Cycle ☐walk ☐Run/walk ☐weight lift ☐Swim ☐Yoga ☐ Other_____

Medications	Current Herbal/Vitamins/Mineral/Supplements	

Cosmetic Procedures & Surgeries, including chemical peels, laser etc

Year	Type	Year	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omission that I may have made in the completion of this form.

Signature: _____ Date: _____

PHYSICIAN – PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered will be determined by submission to arbitration as provided by FLORIDA Law, and not by a lawsuit or resort to court process except as FLORIDA Law provides for judicial review of arbitration proceedings. Both parties to this contract by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury; and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filling of any action in any court by the physician to collect any fee for the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and feed of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness feed, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of the judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joiner in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joiner any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of FLORIDA law, applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable FLORIDA statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the FLORIDA Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below: Patient's Initials: _____

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy. NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Print Name_____Signature_____Date_____

Medical Professional/Group Print Name_____

Representative Signature _____Date_____

MESOTHERAPY-LIPOTHERAPY (Lipodissolve)

CONSENT FOR TREATMENT

I_____ voluntarily consent to undergo Mesotherapy / Lipotherapy (Lipodissolve) treatment(s).

I understand that Mesotherapy can be used for many reasons. I am interested in the following treatment (s): Meso-lift for the face and neck_____; Cellulite_____; Mesotherapy for pain_____; Mesotherapy for Alopecia (hair loss); Acne_____, Mesotherapy for Scars and stretch marks_____, Mesotherapy / Lipotherapy (Lipodissolve) sculpting for fat reduction_____,

I hereby consent to the Mesotherapy / Lipotherapy (Lipodissolve) treatment of which I understand that more than one (1) treatment is required. I understand that the treatment requires many superficial injections in and around the area (s) to be treated. I understand that the administration of topical anesthesia may be used if deemed needed.

I understand that the benefits with Mesotherapy / Lipotherapy (Lipodissolve) will vary but may include: a decrease of cellulite and fat in targeted areas, increase of skin tone, a decrease of wrinkles, minimize scars / stretch marks, and may eliminate or decrease pain.

I fully understand that there are alternative treatments available for the reduction of wrinkle, cellulite, and pain. The following are lists of alternative treatments have been discussed with me; however, I understand that this list is not in any way considered conclusive of all other available treatments.

*face lift	*derma-brasion	*facial peels
*liposuction	*endermologie	*prolotherapy
*pain medication	*nerve blocks	*cortisone injections

I understand that there are some risks with any procedure. The following is the list of possible risks with Mesotherapy.

- ☐ Bruising of the skin is possible
- ☐ Swelling, Redness, Itching, and Nodules are possible depending on location treated.
- ☐ Nausea, dizziness and possible allergic reaction to the Hyaluronidase may occur
- ☐ Skin infection is a possibility with any injection type procedure
- ☐ Skin ulcers in rare instances have been reported
- ☐ I understand that Mesotherapy is new in the United States, but has been used in France and Europe for over 50 years. I understand that Lipotherapy (Lipodissolve) has been used in Europe and South America for over 10 yrs. The medications utilized in treatment are FDA approved but may be used for off label purposes.

I acknowledge that I have been informed about the medications that will be used in my treatment and give consent to their use in my treatment. I know that Mesotherapy / Lipotherapy (Lipodissolve) is not an exact science; therefore, no guarantee can be made as to the results of my treatment. I understand that this treatment is elective and strictly for cosmetic purposes and will not be covered by insurance. I understand that I am responsible for all costs payable at the time of service.

I the undersigned and hereby authorize having photographs taken of me and that they may be used as an aid in my treatment, in marketing, or study reporting purposes and that any photographs taken will remain the property of the facility. I understand that my identity will be kept strictly confidential. I also understand that these photographs will help document the progress of my treatment. I hereby authorize and consent to the above-described photography.

By my signature, I certify that I have thoroughly read and understand the contents of this form and the disclosures listed above were made to me. I affirm that I have been given verbal and written post treatment education_____(Initial). I affirm that I am over the age of 18 and am not under the influence of drugs or alcohol. I also affirm that if my medical history or status changes at any time during the course of treatment I will notify my practitioner and the office immediately.

Patient's Signature_____Date_____

Witness Signature_____Date_____

MESOTHERAPY-LIPOTHERAPY-LIPODISSOVE

PRE-TREATMENT INSTRUCTIONS

We recommend a few simple nutrition guidelines both pre-procedure. They can make the difference between a good result and a fantastic one. Please carefully read and follow these instructions before your Mesotherapy treatments.

One week before: Exclude aspirin, gingko biloba, garlic, coenzyme Q10, flax oil, cod liver oil, vitamin A, vitamin E, and any other essential fatty acids.

24 to 48 hours before: Exclude, Niacin, high-sodium foods, high sugar foods, refined carbohydrates ***(you may eat fruit)***, avoid foods with added sugar, fructose, corn syrup, spicy foods, caffeine, alcohol, cigarettes.

The day of treatment: Eat a full breakfast or lunch depending on the time of treatment. Include a moderate amount of protein with meal and 30-40 minutes prior to your visit. Avoid refined sugar, caffeine and carbohydrates. Suggested protein: eggs, cheese, meat, fish or whey protein shake.

Occasionally, patients **will experience nausea** from one of the solutions used and the protein helps prevent the nausea.

1. **Drink plenty of water, & avoid caffeine.**
2. **If you are being treated for cellulite, please wear a black G-string or thong. The black color accentuates the cellulite making it easier to see.**
3. **Please try to wear no make-up.**

Should you have any questions regarding your treatment or preparation for your treatment please feel free to call our office and we will be happy to assist you.

MESOTHERAPY-LIPOTHERAPY-LIPODISSOVE

POST-TREATMENT INSTRUCTIONS

Please carefully read and follow these instructions after your treatment

Drink at least 64 ozs water day of treatment (*Fiji water is recommended due to its high content of Silica)*, preferably more, continue water intake the first week after. Avoid of coffee, soda and high sugar drinks.

Do not wash or take a shower for at least 8 hours after your treatment. Do not take hot baths for 48 hours after your cellulite/body fat sculpting treatment. After 48 hours you may take baths as hot as you can stand for at least 15 minutes. This will assist your body while it absorbs the bruising.

Do not use any lotions, creams or make-up for at least 6 hours after your treatment, but 24 hours is preferred.

48 hours after your procedure you may begin adding your supplements.

Avoid sun exposure for at least 48 hours after your Mesotherapy treatment.

Avoid exercise for 48 hours: Exercising causes you to sweat, which will decrease the effect of the solutions that have been injected into your tissue.

EYE FAT TREATMENT:
Post eye-pad (under eye bags) treatment: Expect swelling for at least 48 hours. You are to remain in a **60 degree vertical position** for 20 minutes and **sleep on 3 pillows for 2 days following treatment. If pain develops in and around the eye call doctor immediately.**

CHIN/JOWL FAT TREATMENT:
Post Chin/Jowl treatment: expect swelling for 48 hours. Sleep w/head and chin wrap (i.e. scarf)

It is normal to experience: Bruising, Redness, Itching, Soreness, Swelling, Nausea, some of these can last from several hours – 30 days depending on the areas treated and medications used. Wobenzyme or Arnicataken orally will help your body heal from bruising and swelling. May be purchased at your local health food store. **Take twice daily** until bruising subsides. **Vitamin K cream** is also helpful after the treatment to minimize bruising.

A small percentage of patients may experience a sensitivity reaction to Hyalurondase. Should that occur **you would notice small lumps the size of quarters** under your skin at the injection sites. You may take **Benadryl every 6-8 hours and apply an OTC cortisone cream, *(such as Hydrocort)*, until they subside.** Please **alert the office** of your reaction; since it will be necessary for you to take Benadryl or a similar medication prior to your next treatment. **Any allergic/sensitivity reaction will remain localized in the area of the injections and will not spread to other parts of the body.**

Please call our office should you have any questions or concerns regarding your treatment or aftercare.

Patient
Signature_____Date_____

Witness
Signature_____Date_____