Informed Consent for Allergan Brand Botox®-A Injection

I ____(full name)

of ____(address)

on this day _______________(date) hereby acknowledge that I have read, understand, and agree to all of the following statements regarding the injection of Allergan Brand Botox®-A.

Please read each statement below and initial after each to indicate agreement:

1. Facial Wrinkle Treatment:
   - I consent to and authorize the staff of Restorative Health Care to perform a Botox® treatment on my facial wrinkles. _________

2. I understand that Botox®-A is a toxin and works by paralyzing nerves and muscles in the injected area. _________

3. I understand that there is no warranty or assurance as to the results of my treatment. _________

4. I understand that the results of Botox®-A treatment are temporary and follow-up treatments are necessary to preserve the effect. _________

5. **The known side effects and complications of Botox®-A treatment are:**
   - Redness, swelling, itching, pressure around the area treated that lasts more than one week.
   - Nodule/bump at the injection site.
   - Discoloration at the injection site.
   - Incomplete effect.
   - Allergic reaction (rare).
   - Effect that lasts less than the expected 3-6 months.
   - Repeated treatment can result in permanent loss of muscle tone in the area treated.
   - Bruising.
   - Facial asymmetry.
   - Drooping eyelid or dry eyes.
   - Paralysis leading to facial droop or double vision.
   - Generalized weakness or flu like symptoms.
   - In rare cases, an individual may develop antibodies (or a reaction) to the Botox®-A toxin.

I have read the list above, and am fully aware of the potential risks, complications and side effects of Botox®-A treatment. I accept these factors and would like to proceed with treatment. _________

6. I have taken the precautions of discontinuing alcohol, aspirin, or NSAID (Ibuprofen, Aleve, Indomethicin, etc.) 1 week prior to treatment. __________

7. **The contraindications to Botox®-A treatment are:**
   - Serious pre-existing disease.
   - Infection of eyes or other potential injection sites.
   - Pregnant.
   - Breast-feeding.
   - Under 18 without parental consent.
   - Routine Blood Donor.
   - Hemophiliac.
   - Known Allergy to Botox®-A.

   I have read the list above, and certify that I have none of the contraindicated conditions. ____________

8. **The after treatment safety precautions include:**
   - No lying down, bending over, or reclining for four hours after injections.
   - No scratching, rubbing, or massaging the treated areas for 24 hours after treatment.
   - Avoid makeup for 1 to 2 hours post-treatment

   I agree to adhere to these safety precautions. ____________

9. I certify that I am competent and above 18 years of age. OR as a minor, I understand that I am required to have written consent from my legal guardian. ____________

10. I agree that any picture taken of me pre- and post-treatment may be used for publication and teaching purposes; however, my name will not be disclosed and the confidentiality of my name will be maintained. ____________

11. I accept that this informed consent is freely and voluntarily executed and shall be binding upon my spouse, heirs, relatives, legal representatives, administrators, successors, and assigns. ____________

12. I agree to pay Restorative Health Care the sum of ___________ for Botox®-A treatment. ____________

13. I certify that I have read this entire form and by signing my initials after each statement, am agreeing to the information given.

Patient:	**Witness:**
Name: ________________________	Name: ________________________
Signature: ______________________	Signature: ______________________
Date: __________________________	Date: __________________________

BRIEF MEDICAL HISTORY *(for Botox Patients Only)*

Name____

Phone________________________________ Age__________ Ht__________ Wt________

Address____

City/State____ Zip__________________

MEDICATIONS:

____

____

ALLERGIES:

____

Women: Are you pregnant or lactating?____________________________________

Physician's Name:____

Circle any of the following illnesses you have or have ever had in the past (or family history):

Myasthenia Gravis　Hepatitis　Eye Disease　Autoimmune Disease

Numbness　Vision Problems　Muscle Weakness

Amyotrophic Lateral Sclerosis (ALS)　Eaton Lambert Disorder

I am not on Aminoglycosides or any other antibacterial medication to treat bacterial infections.

Explain:____

____

Previous Hospitalization/Operations:

____

____

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 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.

Client Signature:

____ Date:__________________

RESTORATIVE HEALTH CARE

PATIENT DEMOGRAPHIC INFORMATION
(PLEASE PRINT)

PATIENT NAME: ________________________________ **SEX: M / F**
First Middle Last Suffix

STREET ADDRESS: ________________________________

CITY, STATE, ZIP CODE: ________________________________

DATE OF BIRTH: ________________ **SOCIAL SECURITY #:** ________________

ETHNICITY/RACE: (CIRCLE ONE) American Indian/Alaska Native / Asian / Black/African American / Hispanic/Latino
Native Hawiian / Other Pacific Islander / White / Other: ________________

HOME PHONE #: ________________ **WORK PHONE #:** ________________

CELL PHONE #: ________________ **ALTERNATE PHONE #:** ________________

WHICH IS THE BEST "DAYTIME" # TO CALL: (CIRCLE ONE) HOME WORK CELL ALT

E-MAIL ADDRESS: ________________________________

PLACE OF EMPLOYMENT: ________________________________

FAMILY DOCTOR: NAME ________________ PRACTICE ________________
PHONE # ________________ FAX # ________________

REFERRING DOCTOR: NAME ________________ PRACTICE ________________
PHONE # ________________ FAX # ________________

SPOUSE'S NAME: ________________________________
First Middle Last Suffix

SPOUSE'S DATE OF BIRTH: ________________ **SPOUSE'S SOCIAL SECURITY #:** ________________

SPOUSE'S PLACE OF EMPLOYMENT: ________________________________

SPOUSE'S PHONE # WITH AREA CODE: ________________ (Circle One) Cell / Home / Work

PREFERRED PHARMACY (Name & Location): ________________________________

....

Please list an emergency contact (someone other than spouse) not living at your address:

NAME OF EMERGENCY CONTACT: ________________________________

RELATIONSHIP: ________________ **PHONE NUMBER:** ________________

NAME OF EMERGENCY CONTACT: ________________________________

RELATIONSHIP: ________________ **PHONE NUMBER:** ________________

____
PATIENT SIGNATURE **DATE**

Notice of Privacy Practices for FamSurg, PLC d/b/a Restorative Health Care

Effective Date of this Notice: January 1, 2015

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can file a complaint if you feel we have violated your rights by contacting Sara Kranz, Privacy Officer/ Office Manager at (925)-933-2962
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

<u>Our Uses and Disclosures</u> - How do we typically use or share your health information?
We typically use or share your health information in the following ways:

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research.

We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as: Preventing disease / Helping with product recalls / Reporting adverse reactions to medications /Reporting suspected abuse, neglect, or domestic violence and preventing or reducing a serious threat to anyone's health or safety

Do research- We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests -We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

RESTORATIVE HEALTH CARE
MEDICAL INFORMATION RELEASE

Patient Printed Name:____

I understand that as part of my healthcare, this practice originates and maintains records describing my health information and I understand that this information can and will be used to:

Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers.

Obtain payment from third-party payers.

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

Signature of patient or patient's representative: ____

Date: ___________________________

One-Time Authorization for Patients with Medicare Coverage

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S. C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

Signature of patient or patient's representative: ____

Date: ___________________________

Notice of Privacy Practice Acknowledgement

I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH RESTORATIVE HEALTH CARE'S NOTICE OF PRIVACY PRACTICES – Effective Date of Notice: January 1, 2015

Signature of patient or patient's representative: ____

Date: ___________________________

Person(s) to whom my medical information can be released

Name: ____________________________________ Relationship: ___________________________

____________________________________ ___________________________

____________________________________ ___________________________

____________________________________ ___________________________

____________________________________ ___________________________

Signature of patient or patient's representative: ____

Date: ___________________________

Billing Policy

The providers and staff of Restorative Health Care would like to welcome you and thank you for choosing us for your specialty needs. We would like to provide you with some introductory information concerning the financial aspects of your encounter in hopes of avoiding any confusion or concerns which may be caused by the somewhat complex process of medical billing as it exists today.

If you are a new patient, when you first contact or are contacted by our office, you will likely be questioned about the type of insurance by which you are covered. This will allow our staff to ensure that the proper referral documents can be obtained to avoid nonpayment of your visit(s). Rest assured that in no way does insurance coverage or non-coverage affect the type of care you receive.

If you are an established patient you will be asked to update your personal information and notify our office of any changes in insurance coverage since your last visit.

At the time of your visit, you will be responsible for any co-payment portion dictated by your insurance carrier. If you are covered by more than one type of insurance, (for example, Medicare and Blue Cross) please let the receptionist know so the proper carriers can be billed.

As with your office visits, you may be responsible for a portion of the procedure fees (deductibles and/or co-insurance) depending on insurance type and policy coverage. Our Financial Policy states after insurance pays on your claim(s) you will receive a statement from our office once the balance becomes patient responsibility. Any account over 30 days old is considered past due.

Our primary mission at Restorative Health Care is to deliver the best care possible to our patients. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible. To assist you with your specialty care, we provide the following payment options once your insurance carrier has processed your claim(s):

1. **Cash-Includes money orders and personal checks**
2. **Visa/MasterCard, Discover and American Express**
3. **Care Credit (for Cosmetic procedures only – Vein Treatments, CoolSculpting & Botox)**

Payment plans are available with very specific criteria in some instances. Please speak with the Billing Manager or Administrator if you are unable to pay with the options listed above. Arrangements must be made in advance.

Thank you once again for choosing us for your specialty medical care. We will assist you in whatever way possible and we ask that you assist us by understanding your insurance policy and the coverage it provides. Although we make every effort to be accurate and concise in our billing process, oversights do at times occur. Please do not hesitate to contact our billing department to answer your questions.

Providers and Staff of Restorative Health Care

Billing Policy Confirmation

I have received and read the Billing Policy provided to me by Restorative Health Care.

I understand I am responsible for any co-payment, co-insurance, and/or deductible amount dictated by my insurance carrier. I understand the payment options available to me.

Patient Signature____Date________________

____Date________________
Signature of Responsible Party (if patient is a minor)