Consent for Neuromodulator Injection Therapy

(Botox Cosmetic®, DYSPORT®, Xeomin®)

Patient Name (*print name*):	Date:

I, the undersigned, hereby voluntarily consent for Essential Woman, LLC. (the "Practice"), through its principal, Cynthia Lombard, APRN-BC ,and its designated certified assistants, to provide Medical Aesthetic Procedural Treatments on me as reviewed part of my plan.

This treatment involves injecting 12-21 sites of the facial muscles with minute amounts of botulinum toxin. This toxin temporarily weakens the facial muscles to give the skin a smoother and more rested appearance. Although the results are usually dramatic, I have been made aware concerning the expected results in my case.

I have been given and reviewed the information about neuromodulators. I understand the benefits develop over 2-7 days and can last 6 weeks to 6 months based on individual variability.

I also understand that a small percentage of people are minimally responsive to the treatment. In some cases, the "response" lessens with repeated treatments due to antibody formation against the toxin.
Side effects and potential complications have been reviewed with me, and can include minor swelling, bruising, eyelid or eyebrow droop, asymmetry of the lower face, or skin rash (in the event of allergic reaction). Rarely, an adjacent muscle may be weakened for several weeks after an injection. Temporary double vision is extremely rare, but has been reported (particularly when used by ophthalmologists to treat spastic eyelid muscles blepharospasm). These effects, along with natural muscle activity, will recover over many weeks to months. I have been advised of the post-treatment instructions and understand these should be followed to minimize risk of complications.

Authorization for disclosure of information: I authorize Cynthia Opatz Lombard, APRN-BC to disclose complete information concerning her medical findings and treatment of the undersigned, from the initial office visit until the date of the conclusion of such treatment, to those individuals who, in Cynthis Opatz Lombard, APRN-BC's sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.
I understand that any medical treatment may involve risks as well as the proposed benefits.

_____ I have been advised of the risks involved, the expected benefits, and the alternative treatments, including no treatment at all.

_____ I agree that this constitutes full disclosure. I certify that I have read and fully understand the above paragraphs, and that I have had sufficient opportunity for discussion and to ask questions.

I understand that an appointment will be scheduled the day of treatment for my 2-week cosmetic follow up, which will include having pictures taken.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your provider now before signing this consent form.

Patient Signature (*or legal guardian, please identify below*):	Date:
If signed by a legal guardian above, please print name and relationship to patient:	Relation:

Consent for Cryolipolysis / Body Contouring Therapy

PART 1 OF 2

Patient Name (*print name*):	Date:

I, the undersigned, hereby voluntarily consent for Essential Woman, LLC. (the "Practice"), through its principal, Cynthia Opatz Lombard, APRN-BC and its designated certified assistants, to provide Medical Aesthetic Procedural Treatments on me as reviewed part of my unique plan.

The Cryolipolysis procedure is a non-invasive procedure that delivers controlled cooling at the surface of the skin to kill fat cells. It is not a weight-loss solution, and it does not replace traditional methods such as liposuction. Clinical studies have shown that the Cryolipolysis (CoolSculpting) procedure will naturally remove fat cells but, as with most procedures, visible results will vary from person to person.

What you can expect: *(Please Review and Initial each Item below)*

_____ 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 as the area becomes numb.

_____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.

_____ Bruising, swelling, and tenderness can occur in the treated area and it may appear red for one to two weeks after treatment.

_____You may feel a dulling of sensation in the treated area that can last for several weeks after the procedure. Other changes – including swelling, itching, tingling, numbness, tenderness to the touch, pain in the treated area, cramping, aching, bruising and/or skin sensitivity – also have been reported.

_____Patient experiences may vary. Some patients may experience a delayed onset of the previously mentioned symptoms. Contact us immediately if any unusual side effects occur or if symptoms worsen over time.

_____You may start to see changes in as early as three weeks after your Cryolipolysis 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.

_____Additional treatments may be needed to reach your desired outcome.

_____ In rare cases, patients have reported darker skin color, hardness, discrete nodules, freeze burn, enlargement of the treated area, hernia or worsening of existing hernia following the Cryolipolysis procedure. Surgical intervention may be required to correct tissue enlargement or hernia formation. I understand that these and other unknown side effects may also occur.

Consent for Cryolipolysis / Body Contouring Therapy

PART 2 OF 2

Patient Name (*print name*):	Date:
Do you have any of the following? *(please answer all questions)*	
Cryoglobulinemia or paroxysmal cold hemoglobinuria	Yes / No
Known sensitivity to cold such as cold urticaria or Raynaud's disease	Yes / No
Impaired peripheral circulation in the area to be treated	Yes / No
Neuropathic 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 concomitant 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	Yes / No
Any active implanted devices such as pacemakers and defibrillators	Yes / No

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I understand that any medical treatment may involve risks as well as the proposed benefits. I have read the above information, and I give my consent to be treated with the Cryolipolysis /Body Contouring Therapies by Cynthia Opatz Lombard, APRN-BC and her designated certified staff.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your provider now before signing this consent form.

Patient Signature (*or legal guardian, please identify below*):	Date:
If signed by a legal guardian above, please print name and relationship to patient:	Relation:

Patient Informed Consent for Appetite Suppressants

Patient Name (*print name - person authorizing*):

Procedure and Alternatives:

- I authorize Essential Woman, LLC (the "Practice"), through its principal, Cynthia Opatz Lombard, APRN-BC and its designated assistants, to assist me in my weight management efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks, and that I have understood all the risks and benefits, including fatal risks of use of such medications and the duration of treatment.

- **I have read and understand my doctor's statements that follow:**

  Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The Practice and its team members are not responsible for any manufacturing/ingredient changes, and other individualistic pharmacologic parameters for each medication and its manufacturer.

- I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible. **I will notify the physician if I am taking any anti-depressant medications, any mood or other behavioral changes. Some of these medications may cause suicidal ideation and or homicidal ideation and I understand significance of these risks associated with the medications and opt to proceed with using the medication.**

- I understand the purpose of this treatment is to assist me in my desire to get to a better, healthier weight in a safe manner. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance, and side effects and associated symptoms. If the Practice or any of its team members feel the medication may not be safe for a particular patient, they will discuss other options with me for my safety.

- I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an ex-change eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

- **Risks of Proposed Treatment:**

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks involves some risk and hazards. The more common include nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

Patient Informed Consent for Appetite Suppressants

(Continued)

Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with elevated body mass index. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees.

I also understand that as I start to lose weight, I may need changes in other medications for optimal and safe weight management and prevention of serious complications. It is my responsibility to update all my healthcare team members about my medications.

No Guarantees:

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful.

Patient's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

WARNING

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, **ASK YOUR DOCTOR NOW BEFORE SIGNING THIS CONSENT FORM**.

Patient Signature (*or legal guardian, please identify below)*:	Date:
If signed by a legal guardian above, please print name and relationship to patient:	Relation:

PROVIDER DECLARATION

I have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of elevated body mass index. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

Provider Signature:	Date: