Bio Identical HRT

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I confirm that I understand these procedures and elective medical-cosmetic treatment and hereby acknowledge the following points:

I confirm this health history is accurate and complete. I understand that withholding any medical information may be detrimental to my health and safety during the procedure which the practitioner agrees to undertake. If there are any changes in my medical history, it is my responsibility to advise the practitioner before further treatments are carried out. *

◯ No ◯ Yes

That the practice of medicine is not an exact science and different people can react differently to one procedure. In particular, the effects of the treatment will last linger on some patients than others *

◯ No ◯ Yes

That this procedure and treatment is performed by suitably qualified professionals who are being trained how to administer non-surgical aesthetic treatments under close supervision by experienced practitioners. I am therefore aware and acknowledge that I am being treated in a training environment. Therefore, the results are subjective and while I have been advised as to the expected results, this should in no way be interpreted as a guarantee for 'perfect results' *

◯ No ◯ Yes

I have complete understanding that any treatment I undergo will incur a reduced financial fee as I am being treated in a training enviroment. *

◯ No ◯ Yes

It is my own decision to receive non-surgical treatments with xxxxxxxxxxx in a training environment; I have been made aware of alternative treatments including the option of having no treatment *

◯ No ◯ Yes

I confirm that by signing this consent form, I have responsibility to inform of any change in my medical history and that I will follow all aftercare advice on every treatment. *

◯ No ◯ Yes

I further understand that for teaching purposed, pre and post photographs will be taken and that these will be used by xxxxxxxxx and their associated companies *

◯ No ◯ Yes

I agree to follow all aftercare information provided to me. I have been advised and given the written aftercare advice for the treatments. I understand and agree that deviating from any aftercare advice can cause disappointing results, and may pre-dispose me to side effects and reactions to the treatment. *

◯ No ◯ Yes

I can confirm I understand all of the above and consent to treatment today.

Patient Signature: *

IMAGE AND VIDEO CONSENT FORM

Procedure *: _____

This form enables you to decide what happens to your phone and video recordings after they have been taken. We will respect your wishes and would be greatful if you could answer the following questions regarding how you would like your photographs to be used. Pre and post treatment images are always recorded and handled in accordance with data protection principles. As cosmetic treatments are a very visual speciality it is a requirement that all of our patients have their photographs taken before and after treatment. These photographs are stored securely and we adhere to a strict policy of controlling access to your photographs.

Please select yes or no for the following options

I am happy for my photographs to be shown to other patients considering having this treatment *

◯ No ◯ Yes

I am happy for my photographs and videos to be shown in any xxxxxxxxxxxx marketing materials, including online and in printed advertising. *

◯ No ◯ Yes

I am happy for my photographs and videos to be shared by my supervising trainer across their online channels *

◯ No ◯ Yes

I consent to the choices I have chosen above and confirm that these images & videos were taken with my knowledge. *

◯ No ◯ Yes

How we process your information: We process the Personal Data supplied by you once you have decided to go ahead with any treatment. In order to do this we will pass the information onto third parties in order to obtain the necessary product to do your treatment. Personal data will be stored for up to 10 years. We would draw your attention to your right to request from us access to your personal data as well as your rights to have such data corrected or deleted once it is no longer necessary for the fulfilment of your contract with us.

Patient signature *

Side effects/adverse reactions may include but are not limited to:

Botox • Mild swelling/redness at the injection site for up to 48 hours • Bruising may follow the injections • Headache • Infection/allergic reactions • Rarely, there is a risk of temporary loss of function of nearby muscles such as eyelid ptosis/droop of eyelid • Uncommon side effects may include numbness, dizziness, inflammation of the eyelid, visual disturbances, and muscle twitching. Filler • Bruising, redness and swelling can occur • Asymmetry, over correction or under correction • Unpredictable persistence of filler, shorter or longer than anticipated • Visible lumps /nodules or scarring at the injection site • If you suffer from cold sores the treatment may result in a fresh eruption of the virus • Allergic response to treatment is rare, as is infection • In rare cases discolouration of the injection site, abscess formation, granulomas and haematomas have been reported as has occlusion and compression of blood vessels in the area which can lead to skin necrosis. • Very rare: there have been a small number of reported cases of blindness across the world which may have been attributed to treatment with dermal fillers in the temple area, tear trough and nose reshaping.

Patient Consent *

- ☐ I am not pregnant or breastfeeding
- ☐ I understand and will follow the after care information for my treatment today
- ☐ I am aware that results cannot be guaranteed and are subjective

I (model name) *: _____

have understood the treatment/s that I am receiving today. All the aspects of the treatment have been explained to me and I have discussed and understood the treatment fully. I also understand the aftercare information for my treatment today. I am aware that the results are not guaranteed but the practitioner and delegate will provide the treatment to the best of their knowledge and ability. I hereby give my consent to the practitioner and delegate to complete the treatment of (type the name of the treatment) today and I am aware and have been informed of the risks and possible side effects of the treatment.

Patient Name: *: _____

Patient Signature: *