KYBELLA®

Patient Health History Form

Full Name _____ DOB_____

Street_____ City_____State/Province_____ Zip_____

Emergency Contact/Number/Relationship To Patient

_____

Do you have any health problems or medical conditions? Please list.

_____

_____

_____

_____

Please list ALL allergies you may have (medications, latex, food, pollen, etc.) and briefly describe your reaction (i.e. rash, hives, shortness of breath, etc.) If no allergies, please type NONE.

_____

_____

_____

_____

_____

Please list any medications you're currently taking, including prescriptions and over-the-counter medications, topical creams, facial skin care products, and vitamins and medicinal herbs.

_____

_____

_____

_____

_____

Do you have an active infection? YES NO

Are you pregnant? YES NO

Future Appointments/Contact

How would you like to be contacted to confirm future appointments? _____

Would you like to receive information about future promotions and news?

YES ____ NO____

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Cancellations

We request a minimum of 24 hours notice for cancellation of any scheduled appointments to avoid any unnecessary charges . 50% of your scheduled services will be charged to the card on file without a 24 hour notice and full price of your scheduled appointment if no notice is given. Late arrivals may result in a reduced or canceled service.

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform staff members of Blue Spa of my current medical or health conditions and to update this history. I understand the cancellation policy , and I hereby acknowledge that I have been presented with a copy of the Notice of Private Practices (attached).

Patient Signature:_____Date_____

kybella®
(deoxycholic acid) injection 10 mg/mL

Informed Consent Form

KYBELLA® (deoxycholic acid) injection is indicated for improvement in the appearance of moderate to severe fullness associated with submental fat, also called "double chin," in adults. KYBELLA® is injected into the fat under the chin. Injections will be given at least 1 month apart. Your provider, in conjunction with the patient, will decide how many treatments are necessary. KYBELLA® is intended to treat isolated submental fat; it has no effect on excess neck skin. After dissolving fat, any excess skin may be more prominent.

Please initial each paragraph after reading. If you have any questions, please ask your doctor before initialing.

_____**1**. I understand this treatment may not meet my desired needs or expectations and further treatment may be required.

_____**2**. My provider at Blue Spa has explained that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance, such operative risks include, but are not limited to:

- Swelling, brushing, pain, numbness, redness and areas of hardness in the treatment area.
- Although rare, needles or cannulas can lead to permanent scars at or around the injection sites.
- Tingling, nodule, itching and skin tightness in the treatment area.
- Headache.
- Nerve injury in the area of the jaw resulting in an uneven smile or facial muscle weakness.
- Difficulty swallowing.
- Superficial skin erosions.
- Small patches of alopecia (hair loss) in the treatment areas.

_____**3**. I understand that there is a possibility of an unsatisfactory result from injections of KYBELLA®. The procedure may result in unacceptable visible deformities or asymmetry in the treatment area.

_____**4**. I understand that there may be additional risk and/or complications, which remain unknown at this time.

_____**5**. I understand that it is my responsibility to give my provider a full and truthful health history, including:

- Have had or plan to have surgery on the face, neck or chin.
- Have had cosmetic treatment on the face, neck or chin.
- Have had or have medical conditions in or near the neck area.

- Have bleeding problems, are taking blood thinners or any medications that prevent the clotting of the blood (antiplatelet or anticoagulant medicine).
- Are pregnant or plan to become pregnant.
- Are breastfeeding or plan to breastfeed.

_____ **6**. I understand that it is my responsibility to give my provider a full and truthful list of the medications that I am taking, including:

- Prescription medications
- Over the counter medications

_____ **7**. I understand that AFTER TREATMENT are as follows:

- Expect swelling and redness. You may also experience bruising, pain, numbness, and induration (This will normally last less than 5 days but can last up to 14 days. If symptoms continue beyond 10 days or if other reactions occur, contact Dr. Blue directly at 970.618. 0586 or call Blue Spa at 970.927.1004.
- You may elect to ice the area post treatment, but you must do so carefully. Use an ice pack with the fabric side against the skin or wrap a soft plastic ice pack in a thin wet towel. (Apply the ice pack approximately 15 seconds on, 15 seconds off.) I understand icing too vigorously can cause frostbite and/or scarring. You may apply a cold compress to the area for 20 minutes per hour and you may do this hourly for up to 3 days.
- Do not participate in strenuous activity for 3 days following treatment.
- Sleep with your head elevated on at least 2 (and preferably 3) pillows.
- Do not scratch, pick or traumatize the area in any way. Do not massage or manipulate the injection site.
- You may apply your typical skin care regimen and sunscreen normally.
- Please call Dr. Blue or the office if you have any difficulty swallowing, crusting or scabbing, asymmetry of your smile, or any other unusual symptoms. In case of emergency, call 911.

Photographs: Photographic documentation may be taken. I hereby do ____ / do not____ authorize the use of my photographs for teaching purposes.

The practice of medicine and surgery is not an exact science. Although good results are expected, there cannot be any guarantee, or warranty, expressed or implied, by anyone as to the results that may be obtained.

I have read and understand all of the information listed above. I have had ample opportunity to discuss these issues, and all questions have been answered to my satisfaction. I understand that there are other alternative treatments that I could undergo and I elect to receive the KYBELLA® injection(s).

I, hereby authorize Dr. Blue to perform KYBELLA® Cosmetic/Therapeutic Injection on me.

Patient Printed Name _____

Patient Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact our office.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemails, emails, texts, postcards, or letters).

The undersigned have read and understood the Notice of Privacy

Authorized signature of covered person (For minor, Parent or Guardian)

Patient Printed Name _____

Patient Signature _____ Date _____

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