CONFIDENTIAL INTAKE FORM

First Name: _____ Last Name: _____

DOB: _____ / _____ / _____ Age: _____ Sex: **O** Male **O** Female

Street Address: _____ City: _____ Zip Code: _____

Cell Phone: _____ Home Phone:_____

Email Address:_____

Occupation: _____ Work Phone:_____

Primary Care Physician: _____ Phone Number: _____

Referral Information We would appreciate learning how you heard about us? Check one, please:

□ Another medical provider? If so, please specify who:_____
□ Family member or friend who is a patient of this practice (please specify): _____
□ Google □ Yelp! □ Internet □ Other (please specify): _____

In order to best serve your medical needs, we ask that you complete the following questionnaire as completely as possible. The Health Care Consumer (HCC) – Health Care Provider (HCP) relationship is a privileged relationship built on trust and honesty. By completing and signing this form, you acknowledge that you understand that any intentionally false information may seriously and adversely affect your health.

Emergency Contact:

Name:	Address:	
Home Ph:( )	Mobile: ( )	Email:

Chief Complaint/s (Please list in order of importance to you

Medication Name	Dose	Last Taken

Please list all of the medication you are taking. Include over the counter medications, herbs, and vitamins.

Medication Name	Dose	Last Taken

Surgical/Trauma History

Surgery or Procedure	Date of Procedure	Name of Provider

Please list and describe any allergic reaction you have had to food, medication or insect stings

Surgery or Procedure	Date of Procedure	Name of Provider

Have you traveled in the past one year? □Yes □No

Travel destinations: INSIDE/OUTSIDE the United States	Time spent at this destination

Vaccination History: Please check if you had the following vaccinations and indicate the date/s.

Travel destinations: INSIDE/OUTSIDE the United States
O Influenza **O** Pneumonia **O** Tetanus **O** BCG **O** Varicella **O** HPV (Gardasil)

Have you had cold sore breakouts (oral herpes) or Acne in the past year? **O** Yes **O** No
Have you been using Retin-A, Anticoagulants, or Accutane in the last year? **O** Yes **O** No How long: _____

Have you ever had Botox/Dysport/Xeomin for the treatment of fine lines/wrinkles, Migraine headache or Hyperhydrosis (Excessive sweating)? **O** Yes **O** No Please specify: _____ When: _____
Area/s treated: _____ What was the outcome: _____

Have you ever had Fillers such as Juvederm, Juvederm voluma, Radiesse, Restylane or any other form of fillers not mentioned here? **O** Yes **O** No Please specify: _____When? _____
Area/s treated? _____What was the outcome: _____

Have you ever had Sclerotherapy, Laser Vein treatment, Laser skin resurfacing, Laser skin tightening, Laser hair removal, IPL, Laser tattoo removal, or any other laser treatment before? **O** Yes **O** No Please specify:_____
What area/s treated? _____When?_____What was the outcome:_____

Have you ever had Body/Facial contouring, Cellulite treatment, Non-surgical/surgical neck/facelift with Reaction, Radio Frequency or any other type body/face/cellulite treatment? **O** Yes **O** No Please specify: _____
When: _____ Area/s treated: _____ What was the outcome: _____

Have you ever had Glutathione/Vitamin C injections or any other skin lightening treatment/s? **O** Yes **O** No If yes, please specify: _____ When: _____
Area/s treated: _____ What was the outcome: _____

Have you ever had Medical Facials/ Microdermabrasion/Serum infusion/LED/Chemical peels? **O** Yes **O** No
Please specify:_____ When?_____
What area/s was treated:_____What was the outcome:_____

Weight History:

When did you first become overweight? Your age then: Year:
What do you think is the cause of your weight problem?
Your weight goal: Your current weight : Your Height:

What was your highest weight?	What was your lowest weight?
Have you ever stayed the same weight for 10 years or more? **O** Yes **O** No	
Have you attempted to lose weight before? **O** Yes **O** No Most Lbs lost?	# of years ago:
Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, acupuncture…) and describe the results:	
Do you exercise? **O** Yes **O** No If yes, describe the type of exercise and how often:	

Present/Past Medical History

Adrenal Dysfunction	□**Yes** □**No**	Irregular Heart Rhythm	□**Yes** □**No**
Alzheimer	□**Yes** □**No**	Kyphosis	□**Yes** □**No**
Amyotrophic Lateral Sclerosis	□**Yes** □**No**	Liver Dysfunction	□**Yes** □**No**
Anorexia or Bulimia	□**Yes** □**No**	Kidney Failure or Dysfunction	□**Yes** □**No**
Anxiety	□**Yes** □**No**	Malignancy	□**Yes** □**No**
Arteriovenous Malformations	□**Yes** □**No**	Mania	□**Yes** □**No**
Arthritis	□**Yes** □**No**	Muscular Dystrophy	□**Yes** □**No**
Asthma	□**Yes** □**No**	Myocardial Infraction	□**Yes** □**No**
Autoimmune Disease	□**Yes** □**No**	Narcolepsy	□**Yes** □**No**
Bipolar Disorder	□**Yes** □**No**	Obstructive Sleep Apnea	□**Yes** □**No**
Bleeding Disorder	□**Yes** □**No**	Organ Transplant	□**Yes** □**No**
Cataracts	□**Yes** □**No**	Osteoporosis	□**Yes** □**No**
Cerebrovascular Accident	□**Yes** □**No**	Pancreatitis	□**Yes** □**No**
Chemotherapy	□**Yes** □**No**	Periodic Limb Movement Disorder	□**Yes** □**No**
Claudication	□**Yes** □**No**	Perphieral Artery Disease	□**Yes** □**No**
Clotting Disorder	□**Yes** □**No**	Personality Disorder	□**Yes** □**No**
Congenital Heart Defects	□**Yes** □**No**	Pitutiary Dysfunction	□**Yes** □**No**
Coronary Heart Defects	□**Yes** □**No**	Polycystic Ovarian Syndrome	□**Yes** □**No**
COPD	□**Yes** □**No**	Pulmonary Artery Hypertension	□**Yes** □**No**
Cystic Fibrosis	□**Yes** □**No**	Pulmonary Fibrosis	□**Yes** □**No**
Depression	□**Yes** □**No**	Radiation Therapy	□**Yes** □**No**
Diabetes	□**Yes** □**No**	Recurrent Infections	□**Yes** □**No**
Dialysis	□**Yes** □**No**	Restless Leg Syndrome	□**Yes** □**No**
Eclampsia	□**Yes** □**No**	Sarcoidosis	□**Yes** □**No**
Endocarditis	□**Yes** □**No**	Schizophrenia	□**Yes** □**No**
Endometriosis	□**Yes** □**No**	Scleroderma	□**Yes** □**No**
End Stage Renal Disease	□**Yes** □**No**	Scoliosis	□**Yes** □**No**
Erectile Dysfunction	□**Yes** □**No**	Seizure Disorder	□**Yes** □**No**
Fibromyalgia	□**Yes** □**No**	Sickle Cell	□**Yes** □**No**
Gallstones	□**Yes** □**No**	Sjogren	□**Yes** □**No**
Gastritis or Ulcers	□**Yes** □**No**	Skin Disorder (Acne, Psoriasis)	□**Yes** □**No**
GERD (reflux)	□**Yes** □**No**	Thalassemia	□**Yes** □**No**
Glaucoma	□**Yes** □**No**	Thrombocytopenia	□**Yes** □**No**
Heart or Valve Defects	□**Yes** □**No**	Thromophillia	□**Yes** □**No**
Hemochromatosis	□**Yes** □**No**	Transfusions	□**Yes** □**No**
Hemorrhoids	□**Yes** □**No**	Tuberculoisis	□**Yes** □**No**
Hepatitis	□**Yes** □**No**	If yes, have you been treated?	□**Yes** □**No**
HIV or AIDS	□**Yes** □**No**	Urinary retention or urgency	□**Yes** □**No**
Hypertension	□**Yes** □**No**	Vasculitits	□**Yes** □**No**
Hypotension	□**Yes** □**No**	Visual defects	□**Yes** □**No**
Hypothyroidism	□**Yes** □**No**	Vocal cord dysfunction/paralysis	□**Yes** □**No**
IBS	□**Yes** □**No**		

Review of Systems: Have you experienced any of the following symptoms?

Constitutional		**Genitourinary**	
Weight Loss or Gain	□**Yes** □**No**	Blood in urine	□**Yes** □**No**
Appetite changes	□**Yes** □**No**	Menstrual changes	□**Yes** □**No**
Fatigue, impairs daily function	□**Yes** □**No**	Urinating that is painful or difficult	□**Yes** □**No**
Fever	□**Yes** □**No**	Erection problems	□**Yes** □**No**

Shakes/sweats from lack of drugs	□Yes □No	Vaginal discharge or bleeding	□Yes □No
Eyes		**Musculoskeletal**	
Eye pain or drainage	□Yes □No	Broken bones	□Yes □No
Visual changes	□Yes □No	Joint pain or swelling	□Yes □No
Dry, irritated eyes	□Yes □No	Muscle aches	□Yes □No
ENT/Mouth		Muscle weakness	□Yes □No
Ear pain or drainage	□Yes □No	Back pain	□Yes □No
Frequent sinus infections	□Yes □No	**Skin/Breasts**	
Hearing changes or loss	□Yes □No	Masses or lumps	□Yes □No
Nosebleeds	□Yes □No	Nipple discharge	□Yes □No
Dizziness	□Yes □No	Rashes, ulcers, cold sores, acne	□Yes □No
Respiratory		**Neurological**	
Blood in your sputum	□Yes □No	Seizures	□Yes □No
Chest tightness	□Yes □No	Coughing or choking with swallowing	□Yes □No
Cough lasting >1, productive or not	□Yes □No	Excessive daytime sleepiness	□Yes □No
Shortness of breath	□Yes □No	Extremity pain or burning sensations	□Yes □No
Wheezing	□Yes □No	Hallucinations	□Yes □No
Chest pain with inhalation/coughing	□Yes □No	Numbness or tingling	□Yes □No
Cardiovascular		Difficult falling asleep/staying asleep	□Yes □No
Chest pain or heaviness	□Yes □No	**Endocrinologic**	
Palpitations	□Yes □No	Hair loss	□Yes □No
Fainting or near fainting spells	□Yes □No	Frequent urination	□Yes □No
Swelling of feet or legs	□Yes □No	Increased thirst	□Yes □No
Shortness of breath lying flat in bed	□Yes □No	Heat or cold intolerance	□Yes □No
Gastrointestinal		**Heme/Lymph**	
Abdominal pain	□Yes □No	Bleeding from gums or nose	□Yes □No
Blood in your stool	□Yes □No	Unexplained bruising	□Yes □No
Constipation	□Yes □No	Night sweats	□Yes □No
Diarrhea or food intolerance	□Yes □No	Swollen, painful lymph nodes	□Yes □No
Heartburn or indigestion	□Yes □No	**Allergy/Immune**	
Vomiting or nausea lasting for >1 day	□Yes □No	Watery eyes	□Yes □No
Swallowing difficulty	□Yes □No	Runny nose	□Yes □No
Psych		Food intolerance	□Yes □No
Anxiety without clear explanation	□Yes □No	Frequent skin sores	□Yes □No
Sadness lasting for day or weeks	□Yes □No		
Hearing Voices	□Yes □No		
Thoughts of hurting yourself	□Yes □No		

Female Patients Only

	Response	Description
Are you are pregnant?	□Yes □No	
Are you breastfeeding?	□Yes □No	
Have you ever used hormone replacement therapy? If yes, how long?	□Yes □No	

**Please note that we require a credit card in order to reserve your initial appointment time. This credit card will only be charged upon missing your appointment, failure to cancel or change your appointment without at least 48 hours' notice.

Patient Signature:		**Date:**
Credit Card Number:	**CVV:**	**Expiration Date:**

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 provided by submission to arbitration as provided by California law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Patient enters into this contract are giving up their constitutional right to have such dispute decided in a court of law before jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties (LaViva M.D. Medical Corp. DBA: vivaMD and Patient) that this agreement shall cover all claims or controversies whether in tort, contract or otherwise and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, , medical group or association, their partners, associates, associations, corporations, partnership, employees (regular and in training), agents, clinics, and/or providers (here in after collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn at the 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 mother's expected child or children.

Filling by vivaMD physician and employee/s (regular or in training) of any action in any court to collect any fee from the patient shall not wave the compel arbitration of any malpractice claim. However, following the assertion of any claim against vivaMD (Physician/s, Nurses, Employee/s (regular or in training), any fee dispute whether or not the subject of any existing court action shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail postage prepaid to all parties describing the claim against vivaMD (Physician/s, Nurses, Employees (Regular or in training), the amount of damage sought, the names, addresses, telephone number/s, email address of the patient and)If applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence and the arbitration shall be governed pursuant to Code of Civil Procedure 1280-1295 and the Federal Arbitration Act (9 U.S.C. 1-4). The parties shall bear their own costs, fees and expenses along with pro rata share of the neutral arbitrator's fees and expenses.

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by vivaMD (Physician/s, Employee/s (Regular and in training) not only after the date is signed (including, but not limited to emergency treatment), but also before it was signed as well.

Article 5: Revocation: This agreement may not be revoked by me-the patient and will govern all medical services received by the patient

Article 6: Severability Provision: In the event any provision(s) of this agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there form and remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this agreement per request.

Notice: By signing this contract I agree to have any issue of Medical Malpractice decided by neutral arbitration and I'm giving up my right to have a jury or court trial.

Print Name: _____ Date: _____

Signature _____

CANCELLATION/BILLING/REFUND/EXCHANGE POLICIES

Our goal is to provide quality medical care in a timely manner. This policy enables us to better utilize available appointments for our patients in need of treatment/medical care. This is how we can best serve the needs of our patients.
If it is necessary to cancel or reschedule your appointment, we require that you call us 24 hours in advance. Credit card is required to hold an appointment.

Credit Card #:_____Exp. Date: _____Code: _____

Late Cancellation and No Shows:

Thank you for selecting vivaMD Medical Spa & Weight Management for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements was made.

All appointments including complimentary consultations and follow-ups canceled with less than 24 hours' notice will result in a charge. This also applies to appointments made the same day and appointments scheduled within 24 hours of appointment time. Late cancellation will be considered "No Show" and you will be held accountable for the following: $150 charge or 50% of treatment session or loss of a session from a purchased package.

How to Cancel Your Appointment
To cancel appointments please call us at (510) 742-5795. If you do not reach a staff member you may leave a brief message on the voicemail. **You may NOT cancel via e-mail**.

I agree that should this account be referred to any agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

vivaMD Medical Spa & Weight Management return/refund or exchange policy is that **ALL SALES ARE FINAL.**

I have read and understand all of the above and have agreed to these statements. My signature attests to the fact that I understand and agree to the information contained within.

Print Name: _____ Date: _____

Signature: _____

PHOTOGRAPHIC/EMAIL/TEXT AUTHORIZATION

I, _____, (please check one of the following:
A. [ ] authorize vivaMD Medical Spa to text/email/take photographs, slides or videotapes of me or parts of my body showing before and after results of procedure(s) for the office use only.

B. [ ] authorize or [ ] do not authorize vivaMD Medical Spa & Weight Management the use of these images, without compensation to me, to be used in office seminars, on websites owned by or operated on behalf of vivaMD for prospective patients, in print advertisements, medical presentation, articles, and on television. (This acknowledgement does not pertain to photographs, slides, or videotapes required for medical charts and/or records.) I further agree for vivaMD to send emails/texts/phone calls regarding any vivaMD matters (i.e. appointment reminders, etc.).
I understand that:
If my answer to question 2 is yes, then I understand and agree to the following:
1. Such photographs, slides or videotapes may be published by vivaMD in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about the procedure/s. I understand that such uses may also include marketing on the behalf of vivaMD and vivaMD may receive direct or indirect remuneration.
2. I will not be identified by name in any of the media described above; however, I also understand that in some circumstances the photographs, slides or videotapes may display features that identify me.
3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to the office of vivaMD. A revocation shall not affect any release of information made prior to revocation in reliance upon this authorization.
4. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from vivaMD.
5. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Information Portability and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by applicable federal and/or state confidentiality rules.
6. A copy of this Authorization is valid as the original. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.
I release and discharge vivaMD and representative from all photographic liability, including photographic liability for negligence, that in any way arises out of: any and all rights that I may have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization; and any claim that I may have had relating to such use and disclosure of those photographs, slides or video tapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.
[ ] Patient is a minor, _____ years of age, and we, the undersigned, are the parents or guardian of the patient and do hereby consent for the patient.

This Authorization is made as a voluntary contribution in the interest of public education and I certify that I have read this Authorization and Release carefully and fully understand its terms.

Print Name: _____ Date: _____

Signature: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is requires by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1990 (HIPPA).

vivaMD Medical Spa & Weight Management commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances:
The following circumstances may require us to use or disclose your health information:
1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and court proceedings in response to a court or administrative order.
3. If required by law enforcement officer.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and nation security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement officials.
8. For Workers Compensation and similar programs.

Your right regarding your health information: **1.** Communication: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask the way we contact you at home, rather than work. We will accommodate reasonable requests. **2.** You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. **3.** You have the right to inspect and obtain a copy to the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing. **4.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to vivaMD. You must provide us with a reason that supports your request for amendment. **5.** Right to a copy of this Notice: You are entitled a copy of Notice of Privacy Practices. You may ask us to give you a copy to this notice at nay time. To obtain a copy of this notice, contact our front desk receptionist. **6.** Right to file complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact vivaMD for further information. All complaint must be submitted in writing. You will not be penalized for filing a complaint. **7.** Right to provide an authorization for other issues and disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact vivaMD for further information.

I hereby acknowledge that I have been presented with a copy of this Notice of Privacy.

Name: _____ Date: _____

Signature: _____

BOTOX CONSENT FORM FOR THE TREATMENT OF FINE LINE AND WRINKLES/MIGRAINE HEADACHES/HYPERHYDROSIS

Being fully informed about your condition and treatment will help you make the decision whether or not to undergo BOTOXTM Cosmetic treatment. This disclosure is not meant to alarm you; it is simply an effort to better inform you so that you may give or withhold you consent for this treatment. Botulinum toxin has been approved by the Federal Drug Administration for treatment of chronic migraine and Hyperhydrosis (excessive sweating). Botulinum toxin does not cure chronic migraine/Hyperhydrosis and it may not be effective in some patients. There have, however, been no serious injuries or deaths resulting from its use for these indications. The administration of botulinum toxin is accomplished by injecting a small amount of toxin into the muscles of the head and neck for the treatment of migraine headache. Dosage must be titrated for each individual. Any benefits resulting from botulinum toxin tend to wear off after about 3 months with a repeat injection required if benefit is to be maintained. Injections are usually done every 3 to 4 months with maximal effect peak achieved by about 2-3 weeks. Botulinum toxin is expensive and you should be sure of what costs you will incur resulting from the injection. The side effects of botulinum toxin used for chronic migraine may include:

Transient, and usually mild, head or neck weakness with head/neck injections • Reduction or loss of forehead facial animation due to forehead muscle weakness • Eyelid drooping (ptosis) • Pain at the site of the injection or ecchymosis (black and blue mark) at the site of injection • Dry eye • Double vision • Potential unknown long-term risks It is also possible that as with any injection, there may be an allergic reaction or no effect from the medication. Reduced effectiveness after repeated injections is sometimes seen and rarely infection at the injection site may occur. All care will be taken to prevent these side effects. If therapy is given over a long time, atrophy and wasting in the muscle injected may occur. Occasionally patients become refractory to treatment because they developed antibodies to the toxin and in this event, therapy needs to the modified.

I have requested LaViva M.D. Medical Corporation (DBA: vivaMD Medical Spa & Weight Management medical staff to attempt to improve my fine lines, migraine headache, excessive sweating, or muscle spasms with BOTOXTM -Allergan Inc. trademark for Botulinum Toxin Type A. These injections have been used for more than a decade to improve the spasm of the muscles around the eye, is now approved by the FDA to improve the appearance of the vertical lines between the brows. A few tiny injections of BOTOXTM Cosmetic relax overactive muscles and soften those vertical lines. Injections in other areas to improve appearance of facial lines have been reported in the literature, but the FDA has not approved those uses. The results of BOTOXTM Cosmetic are usually dramatic, although the practice of medicine is not an exact science and no guarantees can be or have been made concerning expected results. The BOTOXTM Cosmetic Solution is injected with a tiny needle into the muscle; you should see the benefits develop over the next two to 14 days.

I have been advised of the risks involved in such treatment, the expected benefits of such treatment, and alternative treatments, including no treatment at all. I understand that the results are temporary and several sessions may be needed for optimal result. I confirm that I have received all necessary information and vivaMD Medical staff has satisfactorily answered all my questions. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures.. By signing below, I acknowledge that I have read the foregoing informed consent and agree to this treatment with its associated risks. I hereby give consent to perform this and all subsequent treatments. I hereby release Laviva M.D. Medical Corporation (DBA:viva M.D.)Medical doctor, and all other medical providers and employees of this corporation (Regular/ on training) from liability associated with this procedure. I further agree that I received the pre and post-care instructions and will follow.

Patient Name: _____ Date: _____

Patient Signature: _____

JUVEDERM®/JUVEDERM VOLUMA/RESTYLANE INFORMED CONSENT

JUVEDERMTM Ultra Plus, Juveder Voluma and Restylane injectable gel are a colorless hyaluronic acid gel that is injected into facial tissue to smooth wrinkles and folds, especially around the nose and mouth. Hyaluronic acid is a naturally occurring substance found in the human body. The role of hyaluronic acid in the skin is to deliver nutrients, hydrate the skin by holding water, and to act as a cushioning agent. JUVEDERMTM Ultra Plus injectable gel temporarily adds volume to facial tissue and restores a smoother appearance to the face.

JUVEDERMTM Ultra Plus/Restylane injectable gel is injected into areas of facial tissue where moderate to severe facial wrinkles and folds occur. JUVEDERMTM Ultra Plus/Restylane injectable gel temporarily adds volume to the skin and may give the appearance of a smoother surface. JUVEDERMTM Ultra Plus/Restylane injectable gel will help to smoother moderate to severe facial wrinkles and folds. Most patients need one treatment to achieve optimal wrinkle smoothing, and the results last about six months. Most side effects are mild or moderate in nature, and their duration is short lasting (7 days or less). The most common side effects include but are not limited to temporary injection site reactions such as: redness, pain/tenderness, firming, swelling, lumps/bumps, bruising, itching, and discoloration. As with all skin injection procedures there is a risk of infection. JUVEDERMTM Ultra Plus/Juvederm Voluma/Restylane injectable gel should not be used in patients who have severe allergies marked by a history to anaphylaxis or history or presence of multiple severe allergies and patients with a history of allergies to gram-positive bacterial proteins. The following are important treatment considerations for you to discuss with your physician and understand in order to help avoid unsatisfactory results and complications.

- Patients who are using substances that can prolong bleeding, such as aspirin or ibuprofen, as with any injection, may experience increased bruising or bleeding at injection site. You should inform your physician before treatment if you are using these types of substances. - If laser treatment, chemical peeling or any other procedure based on active dermal response is considered after treatment with JUVEDERMTM Ultra Plus/Juvederm Voluma/ Restylane injectable gel, there is a possible risk of an inflammatory reaction at the treatment site.

- JUVEDERMTM Ultra Plus/Juvederm Voluma/Restylane injectable gel should be used with caution in patients on immunosuppressive therapy, or therapy used to decrease the body's immune response, as there may be an increased risk of infection. - The safety of JUVEDERMTM Ultra Plus/Juvederm Voluma/Restylane injectable gel for use during pregnancy, in breastfeeding females or in patients under 18 years has not been established.

I have been advised of the risks involved in such treatment, the expected benefits of such treatment, and alternative treatments, including no treatment at all. I understand that the results are temporary and several sessions may be needed for optimal result. I confirm that I have received all necessary information and vivaMD Medical staff has satisfactorily answered all my questions. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that all my questions regarding the procedure have been answered satisfactorily. By signing below, I acknowledge that I have read the foregoing informed consent and agree to this treatment with its associated risks. I hereby give consent to perform this and all subsequent treatments. I hereby release viva M.D. Medical Spa & Weight loss center, Medical doctor, and all other medical providers and employees of this corporation (Regular/ on training) from liability associated with this procedure. I further agree that I received the pre and post-care instructions and will follow.

Patient Name: _____ Date _____

Patient Signature: _____

RADIESSE® INJECTION INFORMED CONSENT

Radiesse is a resorbable implant product approved by the United States Food and Drug Administration for the correction of moderate to severe facial wrinkles and folds, such as nasolabial folds. Risks and complications that may be associated with Radiesse and the implant procedure include, but are not limited to:

1. Facial Bruising, Redness, Swelling, Itching and Pain: I understand that there is a risk of bruising, redness, swelling, itching and pain associated with the procedure. These symptoms are usually mild and last less than a week but can last longer. Patients who are using medications that can prolong bleeding, such as aspirin, warfarin, or certain vitamins and supplements, may experience increased bruising or bleeding at the injection site. **2. Nodules, and palpable material:** I understand that there is a risk that small lumps may form under my skin due to the Radiesse material collecting in one area. I also understand that I may be able to feel the Radiesse material in the area where the material has been injected. Any foreign material injected into the body may create the possibility of swelling or other local reactions to a filler material. **3. Migration:** I understand that the Radiesse, as with any filler material, may move from the place where it was injected. **4. Infection:** As with all transcutaneous procedures, I understand that injection of any filler material carries the risk of infection. **5. Allergic Reactions:** I understand that Radiesse should not be used in patients with severe allergies, a history of anaphylaxis, or history or presence of multiple severe allergies or hypersensitivity to any of the ingredients in Radiesse. **6. Keloids/Scarring:** I understand that the safety of Radiesse in patients with known susceptibility to keloid formation or hypertrophic scarring has not been studied. **7**. Accidental Injection into a Blood Vessel: I understand that Radiesse can be accidentally injected into a blood vessel, which may block the blood vessel and cause local tissue damage, or potentially even a heart attack or stroke. **8**. Radio-opacity**:** I understand that Radiesse is radiopaque and is visible on CT Scans and may be visible in x-rays. **9. Duration of Effect:** I understand that the outcome of treatment with Radiesse will vary among patients. In some instances, additional treatments may be necessary to achieve the desired outcome. No studies of interactions of Radiesse with drugs or other substances or implants have been conducted. This above list is not meant to be inclusive of all possible risks associated with Radiesse or dermal fillers in general, as there are both known and unknown side effects and complications associated with any medication or dermal filler injection procedure. I understand that medical attention may be required to resolve complications associated with my injection. I understand that I should minimize exposure of the treated area to the sun or heat for approximately 24 hours after treatment or until any initial swelling or redness goes away. The safety of Radiesse for use during pregnancy or in breastfeeding women has not been established.

I have been advised of the risks involved in such treatment, the expected benefits of such treatment, and alternative treatments, including no treatment at all. I understand that the results are temporary and several sessions may be needed for optimal result. I confirm that I have received all necessary information and vivaMD Medical staff has satisfactorily answered all my questions. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that all my questions regarding the procedure have been answered satisfactorily. By signing below, I acknowledge that I have read the foregoing informed consent and agree to this treatment with its associated risks. I hereby give consent to perform this and all subsequent treatments. I hereby release Laviva M.D. Medical Corporation, DBA:viva M.D. Medical Spa & Weight loss center, Medical doctor, and all other medical providers and employees of this corporation (Regular/ on training) from liability associated with this procedure. I further agree that I received the pre and post-care instructions and will follow.

Patient Name:_____ Date: _____

Patient Signature: _____

BOTOX PRE & POST-PROCEDURE INSTRUCTIONS

3 DAYS BEFORE treatment: AVOID topical products such as Tretinoin (Retin-A), Retinols, Retinoids, Glycolic Acid, Alpha Hydroxy Acid, or other "anti-aging" products. Also AVOID waxing, bleaching, tweezing, or the use of hair removal cream on the area to be treated. 7 DAYS BEFORE treatment (to prevent bruising): AVOID blood thinning over-the-counter medications such as Aspirin, Motrin, Ibuprofen, and Aleve. Also avoid herbal supplements, such as Garlic, Vitamin E, Ginkgo Biloba, St. John's Wort, and Omega-3capsules.

Do not drink alcoholic beverages 24 hours before (or after) your treatment to avoid extra bruising. Inform your provider if you have a history of Perioral Herpes to receive advice on antiviral therapy prior to treatment. Do not use BOTOX®if you are using Acutane, pregnant or breastfeeding, are allergic to any of its ingredients, or suffer from any neurological disorders. Please inform your provider if you have any questions about this prior to the treatment.

Day of Treatment: Arrive to the office with a "clean face". Please do not wear makeup. You may bring your own makeup to apply after your treatment. You may experience small bubbles at the injection sites, a mild amount of tenderness or a stinging sensation following injection.

Redness and swelling are normal. Some bruising may also be visible. You may experience some tenderness at the treatment site(s) that can last for a few hours or a few days. You may have bruises in the areas treated.

Immediately After Treatment : It is best to try to exercise your treated muscles 1-2 hours after treatment (e.g. practice frowning, raising your eyebrows, and squinting). This helps to work BOTOX®into your muscles. Stay in a vertical position for six hours following injection. DO NOT "rest your head" or lie down; sit upright. You may apply an ice or cold gel pack 30 seconds on and 30 seconds off to the area(s) treated (avoiding pressure). Once you have adequately cooled/iced the area(s) as instructed and any pinpoint bleeding from the injection site(s) has subsided, you may begin wearing makeup. AVOID placing excessive pressure on the treated area(s)for the first few days; when cleansing your face or applying makeup, be very gentle. AVOID exercise or strenuous activities for the first 24 hours post treatment; you may resume other normal activities/routines immediately. You may take Acetaminophen/Tylenol if you experience any mild tenderness or discomfort. AVOID extended UV exposure /sun exposure and any other source of heat until any redness/swelling has subsided. Be sure to apply an SPF 50 or higher sunscreen. Wait a minimum of 2 weeks (or as directed by your provider) before receiving any laser facial and sauna. treatments.

I have read and received a verbal and written pre & Post-treatment care instructions and will follow them. Patient

Name: _____ Date: _____

Patient Signature: _____

JUVEDERM/RESTYLANE PRE & POST-PROCEDURE INSTRUCTIONS

JUVEDERM PRE CARE INSTRUCTIONS: • Avoid for 10-14 days medications that cause blood thinning or inhibit clotting such as: Aspirin & aspirin containing products, Coumadin, Warfarin, Lovenox, Plavix, Pletal, Ticlid, Trental

CONTRAINDICATION TO JUVEDERM/RESTYLANE TREATMENT INCLUDE:

• Infection at proposed treatment sites • Active inflammatory process at proposed treatment sites • History of keloid formation or hypertrophic scarring • Pregnancy or breastfeeding • Current immunosuppressive therapy If there is a history of facial cold sores, there is a risk of exacerbation. Please discuss with your medical provider medications that may minimize the risk of recurrence. • Multiple injections might be made depending on the site and depth of the wrinkles. After treatment there will be moderate to severe swelling, some redness and bruising. These symptoms will resolve in about 7 days.

JUVEDERM POST CARE INSTRUCTIONS: • **Do NOT** rub/massage or apply pressure on the treated area for 6-8hrs after treatment. • In order to allow the dermal filler to stabilize, **Avoid** overly excessive movements of the muscles in your face for the 1st couple of days, especially during the 1st 24 hours after treatment. • **Do NOT** lie down for 6-8 hours after treatment to avoid the chance of applying pressure on the treated areas (from the pillow) and avoid the risk of rubbing the area accidentally. • **Avoid** yoga or other rigorous exercise activities, extensive sun or heat exposure, and alcoholic beverages for the 1st 24 hours after treatment. • **Avoid** facials and saunas for 24 hours after treatment.

• **Avoid** taking Aspirin, Advil, Vitamin E, Ginger, Ginkobiloba , Ginseng, and excessive Garlic for 2 weeks since this may increase the risk of bruising. • Be aware that any bumps or marks will go away within a few days but it may vary individual to individual. • If you do develop a bruise it will resolve like other bruises you have had in about a week or in some cases longer. There is occasionally some mild pain, swelling, itching, or redness at the site of injection similar to most other injections. Redness may last for 1-7 days, rarely longer. Swelling in the lips usually last for one weeks but can last up to 2 week; and the lips may appear uneven until the swelling subsides.

•You may apply cold compresses 2-5 minutes on and 2-5 minutes off or acetaminophen (Tylenol) to reduce swelling or discomfort 2- 3 times per day during the first 1-3 days if needed. By signing below, I agree that I received verbal and written pre and post-procedure instructions. **I understand that any appointment that I make that is not cancelled within 24 hours I will be charged $150 or 50% of the treatment session cost or the loss of one session from my purchased package.**

Patient Name:_____ Date: _____

Patient Signature: _____

RADIESSE INJECTIONS PRE & POST-PROCEDURE INSTRUCTIONS

RADIESSE PRE CARE INSTRUCTIONS:Avoid for 10-14 days medications that cause blood thinning or inhibit clotting such as: Aspirin & aspirin containing products, Coumadin, Warfarin, Lovenox, Plavix, Pletal, Ticlid, Trental

Contraindications to Radiesse include: 1. History of allergy or reaction to any component of the Radiesse 2. Infection at proposed treatment sites 3. Active inflammatory process at proposed treatment sites 4. History of keloid formation or hypertrophic scarring 5. Pregnancy or breastfeeding 6. Current immunosuppressive therapy 7. If there is a history of facial cold sores, there is a risk of exacerbation. Please discuss with your medical professional. 8. medications that may minimize the risk of recurrence.

RADIESSE POST TREATMENT INSTRUCTIONS:

1. After treatment there will be moderate to severe swelling, some redness and bruising. These symptoms will resolve in about 7 days. 2. Avoid excessive heat such as saunas, hot showers, the hot sun or cooking over a hot stove. This may cause the blood vessels to dilate and cause more bleeding and bruising. 3. Avoid strenuous exercise after the procedure. This may raise your blood pressure and pulse causing more bruising and swelling. 4. Avoid direct sunlight for prolonged periods of time. Wear sunblock to protect your skin. Sunlight may cause permanent discoloration after bruising. 5. Avoid drinking alcohol for 24 hours after treatment. Alcohol may cause the blood vessels to dilate and cause more bruising. 6. Avoid taking Advil, Vitamin E, Ginger, Ginko, Bilboa, Ginseng, and Garlic for 2 weeks after the procedure since this may increase the risk of bruising. You may shower and do most other regular daily activities. 7. You may apply Make-up after the procedure. 8. You may apply cold compresses to the treatment sites to reduce swelling and bruising. 9. We recommend Arnica Montana pills or gel to prevent bruising. 10. Note that any bumps or marks from the extremely small needle sticks will go away within a few hours. If you do develop a bruise it will resolve like any other bruise. There is occasionally some mild pain, swelling, itching, or redness at the site of injection similar to most other injections. Redness may last for 1-2 days, rarely longer. 11. Radiesse is a temporary procedure. In most people the benefits of Radiesse last about 12-18 Months. **I understand that any appointment that I make that is not cancelled within 24 hours I will be charged $150 or 50% of the scheduled treatment session cost or the loss of one session from my purchased package.**

By signing below, I agree that I received verbal and written pre and post-procedure instructions.

Patient Name: _____ Date: _____

Patient Signature: _____