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: _____

KYBELLA® (DEOXYCHOLIC ACID) INFORMED CONSENT

Background: KYBELLA® (deoxycholic acid) is a prescription-strength injection used to treat the double chin (submental fat) in adults. KYBELLA® destroys the fat cells that accumulate in the neck. The then naturally eliminates the fat slowly over a few weeks. Once these cells are destroyed, they can no longer store or accumulate fat. KYBELLA® injection has been FDA approved for cosmetic use only in the double chin (submental area).

KYBELLA® is prepared at a very controlled solution and when injected into the skin with a very fine needle, it is almost painless. Patient may feel a slight burning sensation while the solution is being injected. The treatment takes about 15-20 minutes. Most patients require two to three treatment, but some patient require up to six treatments. Final improvement is assessed twelve weeks after the final treatment.

Risk and Complications : This list is not mean to be inclusive of all possible risks and complications associated with KYBELLA® as there are both known and unknown side effects associated with any medical procedure. The possible side effects of KYBELLA® include but are not limited to:

1. Swelling (edema) in the treatment area **2.** Bruising (hematoma) in the treatment area **3.** Pain in the treatment area **4.** Numbness in the treatment area **5.** Redness (erythema) **6.** Area of hardness (induration) in the treatment area **7.** Ulceration of the skin in the treatment area **8.** Temporary or permanent hair loss at the injection site(s) **9.** Less common side effects include, but are not limited to, tingling, nodules, itching, skin tightness, and headache. These side effects typically resolve without treatment. 10. Other less common but serious potential side effects of KYBELLA® include temporary nerve injury in the jaw that can cause an uneven smile or facial muscle weakness, trouble swallowing, superficial skin erosions, small patches of hair loss in the treatment area, or unsatisfactory results.

Alternatives: KYBELLA® is best used in the treatment of the double chin (submental fat). Alternative treatments for a double chin include surgical treatment such as facelift or neck lift, liposuction, and non-surgical treatments such as energy-based devices.

Photographs: Clinical photographs and their use for shall be used for the patient's medical record. Photographs are not shared with third parties or used for marketing purposes unless express written permission is obtained from the patient.

Contraindications: treatments should not be performed on anyone who has an infection in the area. h as not been studied on women who are pregnant, trying to become pregnant, or breast feeding. Kybella treatments are not recommended for such individuals. KYBELLA® treatments are not recommended for those with medical conditions in the neck area including, but not limited to, difficulty swallowing, those that are planning to have cosmetic surgical treatments in the neck or face area such as facelift or neck lift, those with and enlarged thyroid gland (thyromegaly), or those with a bleeding disorder.

Results: The number of vials and treatments in an estimate of the amount of KYBELLA® required to address the double chin (submental fat). There is no guarantee of results of any treatment and up to six to eight treatments may be needed to achieve a satisfactory result. Follow up is recommended six weeks after treatment.

Payment: Payment is due prior to the time of treatment. All services rendered are charged directly t the patient and the patient is personally responsible for payment. In the event of non-payment, the patient will bear the cost of collection, and/or court cost and reasonable legal fees, should this be required. Touch-ups may be required and payment is required for touch-ups. The regular charge applies to all subsequent treatments. Prices are subject to change without notice. No refund will be given. vivaMD refund/return policy is that are sales are final.

Consent: By signing below, I acknowledge that I have read the foregoing informed consent, I understand it, and I agree to the treatment with its associated risks and complications. The treatment has been explained to me and my questions have been answered satisfactorily. I understand that this is an elective procedure. I understand that I will be injected KYBELLA® with in the area of the double chin (submental fat) with the goal of improving the appearance of the double chin (submental fat). I acknowledge that the number of vials and treatment required is an estimate of the amount of rKYBELLA® required to improve the appearance of the double chin (submental fat) and that there is no guarantee of results on any treatment. I acknowledge that I do not have an infection in the area to be treated. I acknowledge that I do not have a medical condition(s) in the neck area including, but not limited to , difficulty swallowing. I acknowledge that I am not planning to have cosmetic surgical treatments in the neck or face area such as a facelift or neck lift. I acknowledge that I do not have and enlarged thyroid gland (thyromegaly). I acknowledge that I do not have a bleeding disorder.

I certify that if I have any change in medical history, I will notify vivaMD medical professional immediately. I authorize clinical photographs to be taken for my medical record. I will follow all aftercare instructions as it is crucial I do so for healing. I hereby voluntarily consent to the current and subsequent treatments with the above understood. I hereby release the person injecting, and LaViva M.D. Medical Corp. (DBA: vivaMD) and its doctor and nurses from any and all liabilities associated with this treatment.

Patient Name: _____ Date: _____

Patient Signature: _____

KYBELLA® Before & After Treatment Instructions

Before treatment:

1. If you've started any antibiotics or other medications since your initial visit, please let us know. You may not be treated if you are pregnant or nursing, have difficulty swallowing, nerve injury or weakness in the lower face, or an infection in the treatment area. Inform vivaMD medical professional if are on blood thinners, or have had procedures or surgery of your face or neck. **2.** Avoid aspirin for 10 days, ibuprofen (Motrin, Advil), other non-steroidal medications (Aleve) and Vitamin E, St. John's Wort, and fish oil supplements for 5 days prior to the procedure, because these medications /supplements will make you more likely to bruise. If you have been prescribed one of these medications/supplement, ask your prescribing doctor before you stop taking it. Tylenol will not cause bruising and is preferred for the week prior to treatment. To avoid possible discomfort, you may take 1g of acetaminophen (i.e. Tylenol) one hour prior to your scheduled appointment. **3.** Plan your procedure so that you can have 4 full days before returning to work or important social engagements. Consider having scarf or other neck covering available to camouflage any swelling or bruising. **4.** Have Ibuprofen (Motrin, Advil) and Zyrtec (an antihistamine) available at home for discomfort and itching that may result from the procedure.

After treatment:

1. After your treatment, you should expect swelling and redness. You may also experience bruising, pain, numbness, and induration. This will normally last less than 5 days, and for some patients may last up to 14 days. If the symptoms continue beyond 14 days or other reactions occur, please contact the office at (510) 742-5795. **2.** You may elect to ice the area post treatment but must do so very carefully. Use an ice pack with the fabric side against the skin, or wrap a soft plastic ice pack in a wet thin towel. Apply the ice pack approximately 15 seconds on, and 15 seconds off. Icing too vigorously can cause frostbite and 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 **3.** Do not participate in strenuous activity for 3-5 days following treatment. **4.** You may apply your normal skin care regimen and sunscreen 2 days after treatment. **5.** Sleep with your head elevated on at least 2 and preferably 3 pillows for the first week after the treatment. **6.** Do not scratch, pick or traumatize the area in any way. Do not massage or manipulate the injection site. **7.** Call the office at (510) 742-5795 if you have any difficulty swallowing, crusting or scabbing, asymmetry of your smile or any other unusual symptoms. In case of emergency call 911. I acknowledge that I have received verbal and written before and after treatment instructions and agree to follow.

Patient Name: _____ Date: _____

Patient Signature: _____