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: _____

CONSENT FOR LASER HAIR REMOVAL/LASER VEIN /SKIN RESURFACING/SKIN REJUVENATION/FUNGAL TREATMENT….

This form is designed to give you the information you need to make an informed choice of whether or not to undergo laser treatment. If you have any questions, please do not hesitate to ask. Although the laser treatment is effective in most cases, no guarantee can be made that a specific patient will benefit from the treatment. The laser emits an intense beam of light that is absorbed in specific body tissues within the skin, and depending upon the type of procedure, several treatments may be required at intervals specified by the medical professional.

Some of the possible complications of laser treatment follows:

1. Discomfort – The procedure is done so precisely that surrounding tissue is minimally affected; the patient may experience a mild sensation of pain in the treated areas. Some degree of skin flushing may occur, but it typically resolves within several hours.
2. Scarring – There is a small chance of scarring, including hypertrophic scars, or very rarely, keloid scars. Keloid scars are very heavy raised scar formations. To minimize chances of scarring, it is important that you follow all postoperative instructions carefully. It is important that any prior history of unfavorable healing be reported.
3. Pigmented changes – The treated area may heal with lighter or darker pigmentation. This occurs more often in darker pigmented skin and following exposure of the area to the sun. It is recommended that you protect yourself from any sun exposure for at least three months following treatment. Hyperpigmentation usually fades in three to six months. However, pigment change can be permanent.
4. HSV Reactivation – The patient agrees to notify vivaMD Medical professional if he/she has any history of Herpes viral infections, as the laser procedure may cause it to reactivate.
5. Lack of Treatment Response – There is a possibility that the targeted hairs, veins or other treated areas will not respond to the treatment. This is often a function of the specific body chemistry of the patient, including relative pigmentation and light absorption characteristics of the patient's various body tissues.
6. Eye Exposure – There is also the risk of harmful eye exposure to laser surgery. Safeguards should be provided by the laser practitioner. It is important that you keep your eyes closed and have protective eye wear at all times during the laser treatment.
7. Photographs – I consent to be photographed before, during, and after the treatment and that these photographs shall be the property of LaViva M.D. Medical Corporation and will not be published without an explicit consent.

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 also agree to 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.
I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs, and that I have had sufficient opportunity for discussion and to ask questions. I agree that all my questions were answered to my satisfaction. I consent to this and any subsequent laser treatment.

Patient Name: _____ Date: _____

Patient Signature: _____

LASER SKIN RESURFACING PRE &POST TREATMENT INSTRUCTIONS

PreTreatment: It is important to follow all instructions:

- For 6 to 8 weeks prior to treatment, avoid sun exposure, as well as tanning beds and self-tanners
- If you are tanned, you may not be treated. Use a sunscreen with a 40+ SPF (recommend: Obagi or Colorscience) at all times and reapply as directed by the manufacturer. Sun exposure is defined as direct sun exposure without protection for ten or more minutes
- Stop using Tretinoin (Retin-A, Differin) and RETINOL products 7 days before treatment. Okay to use other skin care products that do not irritate the skin.
-No aspirin or alcohol 7-10 days prior to treatment. -
Pick up pre-treatment prescriptions: 1) For patients that get cold sores, an antiviral medication such as Acyclovir 400mg, may be prescribed twice daily for 7 days. Start 1 day prior to procedure. 2) A steroid, such as Medrol dose pack, may be prescribed for swelling. Antibiotics may also be prescribed.
- Pick up supplies required for post treatment: 1) Hairband 2) Alta MD Laser Balm 3) Biafine 4) White or apple cider vinegar (small bottle) 5) Obagi Gentle Cleanser 6) Oxygenetix Moisturizer 7) Benadryl 8) Hydrocortisone 1% 9) Oxygentix or Jane Iredale Mineral Makeup (optional) 10) Obagi/Colorscience Sunblock (optional) .
- Make sure you do not have anywhere you need to be the next day or two……...
- Get supplies, movies and groceries before you get treatment. Swelling is worse the first day after treatment; most people will not want to go in public for 2-3 days
- If you are a man and your face and neck are being treated, you should be clean shaven before the procedure.

Day of Treatment

- On treatment day, you should wear comfortable clothes and shoes. If your face or neck is being treated, wear a button-down shirt and bring a hat that provides protection post treatment. Do not wear makeup. You should not wear a watch or any jewelry on treatment day. If you wear contacts, do not wear them on treatment day; bring your eyeglasses instead. Take Tylenol 500-650mg if your medical history allows 1 hour before treatment.

Post Treatment

First 24 Hours:
- DO NOT WASH SKIN! Apply Biafine and Alta MD Laser Balm over the treated areas as needed for moisture.

In the evening:
- Elevate head of bed with 2-3 pillows; use old pillowcase and apply thick layer of Biafine or Alta MD Laser Balm over skin before bed. If you skins dries out during the night, reapply as needed.
- If you have problems with itching, okay to use over the counter Hydrocortisone 1%. You can take Benadryl at night to sleep. If you take Benadryl, avoid driving or operating machinery.

Day1 And 2
- Wash 2-3 times a day with gentle cleanser. DO NOT SCRUB, lightly use fingers and reapply Biafine and Alta MD Laser Balm. It is important to keep it clean to avoid infection.

Day 2
- Start vinegar soaks: Put 1 tsp vinegar in 1 cup cool water and place moist wash cloth over skin for 10-15 minutes. Rinse and reapply Oxygenetix moisturizer. Do this 2-3 times a day.This will help with breakouts and keep bacteria counts down.
- Following treatment normal activities may resume per level of comfort. However, no swimming or using hot tubs/whirlpools while redness is present, usually 24-48 hours.

Day 3 thru 7
- Skin will have a brown appearance until peeling starts. Okay to use high-grade mineral makeup after Day 3. We recommend Oxygenetix Foundation or Jane Iredale Mineral Makeup.

Day 8
- Okay to resume regular skin care, EXCEPT Retin-A or Retinol products. Can start using Retin-A and Retinol products 10-14 days or when skin is no longer pink.
- Shaving(if applicable) can be resumed once you feel comfortable but be careful water is not too hot. If there is any increase in pain or increase in skin redness or excessive swelling, call vivaMD Medical Spa & Weight Management promptly. Please keep all follow-up appointments with vivaMD medical professional to access treatment progress. If you have any questions about these instructions or the procedure, please contact us at (510) 742-5795

Patient Name (Print): _____ Date: _____

Patient Signature: _____

LASER SKIN TIGHTENING PRE & POST TREATMENT INSTRUCTIONS

Pre Laser Treatment Instructions: - Avoid the sun for two weeks before and after your laser treatment. Sunexposed skin is more susceptible to injury during laser applications. Recently tanned skin cannot be treated. Laser treatment within 1-2 weeks of skin tanned naturally or in a tanning booth may result in hypopigmented (white) spots after treatment. These spots may not clear for several months.

- Avoid topical medications for a week prior to the treatment. The use of self-tanning products must be discontinued 2 weeks prior to treatment. Any residual self-tanner must be removed prior to treatment. For best results, we recommend a microdermabrasion 1 to 2 weeks prior to your laser treatment. Microdermabrasion is a noninvasive procedure which gently exfoliates the top layer of your skin, whisking away dead skin cells.

Post Laser Treatment Instructions: Immediately after treatment, there should be redness and swelling of the treatment areas, which may last up to 2 hours or longer. The redness may last up to 2-3 days. The treated area will feel like a sunburn for a few hours after treatment. - A topical soothing skin care product such as Aloe Vera, Aquaphor or a post-peel recovery cream may be applied after your treatment. Ice or cool gel packs may be soothing immediately following treatment. - Make-up/cosmetic products may be used immediately after the treatment,as long as the skin is not irritated. - Your skin will be sensitive for the first week or so after treatment, so do not use products that will cause irritation during this time. Do not use abrasive scrubs, toners, or products that contain alpha or beta hydroxy acids, or retinoids (i.e. Tretinoin, Retin A, Tazorac, Differin, Renova). The Post procedure solution kit should be used for a minimum of 5 days following the treatment. - Avoid sun exposure to reduce the chances of hyperpigmentation (dark spots). - Avoid picking or scratching of the treated skin. - There are no restrictions on bathing except treat the skin gently, as if you had a sunburn, for the first 24 hours after treatment. - Wear plenty of SPF 35+ several times a day at all times throughout the course of treatment and avoid large amounts of sun exposure if at all possible. If sun exposure is necessary, wear clothing that covers the treated areas. - Apply a light cream moisturizer whenever feeling dry. Heavy ointments such as Vaseline may clog your pores and cause mild breakouts, so just remember to keep your skin moisturized. - Avoid Botox, Collagen Injections for seven days after treatment.

What to Expect: ***1. Swelling*** - usually will last two to three days, and will often appear the worst on the day after treatment, especially around the eyes. Elevate your treated area on one or two pillows the first night and apply cold compresses to the treatment area for 10 minutes of every hour for the first one to two days. **2.** ***Redness*** – Avoid putting makeup for the first two days; slight redness could remain for up to one week. **3.** ***Dry skin*** – this procedure tends to cause the skin to flake and feel dry- this is normal and should resolve within two weeks. **4.** If you have areas of raw skin post treatment, keep them moist with something like Aquaphor or Bacitracin. You do not have to apply band-aids, but keep them moist and *do not pick at them*. They will heal on their own. **5.** Healing time also varies from person to person. Be patient with your healing process. We are confident you will see improvement of your skin texture shortly after even the first treatment.

Patient Name: _____ Date: _____

Patient Signature: _____

LASER VEIN TREATMENT PRE & POST TREATMENT INSTRUCTIONS

Pre Treatment Instructions: 1. Discontinue medications or supplements that may thin your bloodone week prior to vein treatments to minimize bruising and improve the success of your treatment. This includes fish oil, flax seed oil, Vitamin E, ginkgo biloba, anti-inflammatory medications (ibuprophen, motrin, aleve), and red wine. **2.** If you are taking aspirin electively and not upon the advice of your physician, then you may stop it for 48 hours prior to your treatment. **3.** Do not stop aspirin if prescribed or recommended by your physician. **4.** You may wish to bring a pair of shorts to wear during your treatment if you are having your legs treated. **5.** If facial veins are being treated, there may be minor bruising and/or swelling following treatment. This can typically be covered using makeup. Plan accordingly since your face may show slight evidence of the laser treatment for a week or more. **6.** If leg veins are being treated, there may be minor bruising, discoloration, and welting over treatment sites. **7.** Larger leg veins may appear bruised for a period of time after treatment. Full results can take weeks or months to be realized. Plan and schedule treatments accordingly, allowing for healing time and time for your treatment results to evolve to completion. The best time to treat leg veins are in fall, winter and spring when you are less inclined to wear shorts or be exposed to sun. **8.** Plan treatments allowing for a period of no sun exposure, vigorous activity or use of hot tubs, saunas or spas for 72 hours after treatment.

Post Treatment Instructions: 1. Please be advised that you may expect a certain degree of discomfort, redness, and/or irritation during and after treatment. If any discomfort or irritation persists, please notify the clinic. - It is helpful to elevate your legs for the first 48 hours. We also recommend wearing support hose for at least 72 hours after leg vein treatments. **2.** After your treatment, it is not uncommon for the treated veins to remain visible for 3 to 6 weeks before dissipating. This is due to residual clotted blood in the vessel. **3.** In some cases, the treated skin may blister. Do not scratch or open the blister—this could cause permanent scarring and/or infection. Keep the areas clean and apply antibiotic ointment such as Polysporin. Treated correctly, the blister will heal without scarring. **4.** A red scab may form under the skin. It may appear for a few weeks and then will be reabsorbed by the body. This is supposed to happen and is a sign of a successful treatment. You can expect treated areas to remain somewhat red and swollen for the first 24 to 48 hours. In some cases, this may last up to 1 week. - Brown spots or hemosiderin staining is caused by a release of iron from the re-absorption of veins and can remain for up to 6 months. **5.** It is possible to have pain from treatment of larger veins for several days post treatment. Tylenol and/or Arnica is recommended for any discomfort. - For best results, do not engage in vigorous aerobic activity such as running, hiking, or aerobic exercise for approximately 72 hours post treatment. **6.** It is advised to remain out of the sun for one week. It is recommended that you use medical grade sun block for any sun exposure. - The skin of the treated areas may tend to itch. This is a sign of healing. Keep areas hydrated with moisturizer and apply hydrocortisone cream to itchy areas 3-4 times daily until itchiness subsides. - Bruising is another common side effect to laser treatment. Bruising is temporary and will dissipate within a matter of days or weeks depending on your individual healing process. Arnica is recommended if you have a tendency to bruise. Arnica helps reduce bruising and eases the soreness of bruising.

Patient. Name: _____ Date: _____

Patient Signature: _____

LASER HAIR REMOVAL PRE & POST TREATMENT INSTRUCTIONS

The duration of hair growth cycle varies on the body location being treated. The laser can only eliminate hair while it is in its' active growth phase. Multiple treatments are necessary over 5-8 week intervals to remove hair from most areas. A minimum of 4-5 weeks in between treatments is required to achieve maximum results. Treatment duration various from 15-120 minutes depending on the size of the area and the amount of hair. It may take up to 3 weeks for the hair to fall out of the follicle. Results may not be apparent for several months post treatment.

Pre Treatment Instructions:

- Avoid sun exposure for at least 2 weeks before the treatment. Apply UVA/UVB sunscreen SPF 35 or higher to any treatment area 30 minutes prior to sun exposure. - Treatments cannot be given on areas with a spray tan, sun tan or sun burn. Do not use tanning beds, lotions or artificial tanning products for a minimum of two weeks prior to your treatment. - Do not wax, tweeze, use depilatories or bleach the area for at least four weeks prior to the treatment. - Shave the area to be treated 12-24 hours prior to the treatment. - Do not wear makeup, creams or lotions directly prior to the treatment.

If you arrive for your appointment and you have not followed the above procedures or did not come 30 min prior to your appointment for the application of numbing cream, we will not be able to treat you and you will be charged according to our policies.

Post-Care Instructions:

- Immediately after the treatment there may be redness and bumps at the treatment site, which will last up to two hours or longer. It is normal for the treated area to feel like sunburn for a few hours. You may use a cold compress, aloe-vera gel, or 1- % hydrocortisone if needed. - Makeup may be used after the treatment, just make sure that you have moisturizer on under your makeup. In fact moisturizer can help the dead hair exfoliate from the follicle so use moisturizer frequently and freely on the treated area. - Avoid sun exposure for four to six weeks after the treatment to reduce the chance of dark and light spots. Use sunscreen SPF 35 or greater at all times throughout the course of the treatment. - Do not use any other forms of hair removal methods or products on the treated area during the course of the laser treatment (tweezing, waxing and depilatories), as it will prevent you from achieving your best results. You may shave the area if needed. - Anywhere from five to fourteen days after the treatment, shedding of the hair may occur and this may appear as new hair growth. This is not new hair growth, but dead hair pushing its way out of the follicle. You can help the hairs exfoliate by taking a hot shower and rubbing with a washcloth or loofa sponge.

By signing below I acknowledge that I agree to the above statements and all my questions were answered to my satisfaction.

Patient Name:_____ Date: _____

Patient Signature: _____