HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

- Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately.
- Patient files may be stored in open file racks and will not openly contain any information which identifies a patient's condition or information which is not already a matter of public record. Such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff .
- It is the policy of this office to contact patients regarding their appointments, past or current care, office policies , information and updates through telephone, text-message, e-mail, or by any means convenient for the practice unless specifically requested by you otherwise.
- The practice utilizes vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
- You understand and agree to inspections of the office and review of documents which may include PHI by government agencies in normal performance of their duties.
- You agree to bring any concerns or complaints regarding privacy to the attention of the office staff.
- We agree to provide patients with access to their records in accordance with state and federal laws.
- We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
- We agree to NOT share any of your confidential chart information or patient photos unless you specifically give us permission to through a separate agreement form.
- You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

By providing my signature below I, _____ consent and acknowledge my agreement to the terms above regarding HIPAA and any subsequent changes in office policy.

Signature:_____Date:_____

Botox / Xeomin / Dysport / Jeuveau Procedure Consent

Botox/ Xeomin/Dysport/Jeuveau are prescription medications for adults that can be injected into the muscles to temporarily reduce movement. Areas that may be treated include: forehead, around the eyes, in-between the eyebrows, chin, around the lips, jawline, neck, neck bands, and underarms. The effects of Botox/Xeomin/Dysport/Jeuveau begin about 2 - 5 days after injection. The full effect of these products can take up to 14 days. Should you require a treatment touch-up, you must wait 14 days after your initial injections. There may be an additional charge at your touch-up visit for the product upon provider's discretion. The effects last around 3 months, depending on each individual.

Common side effects include: bleeding/bruising/swelling at injection site, discomfort or pain at injection site, temporary redness or skin irritation, dry mouth, headache

Other side effects include but are not limited to: paralysis of nearby muscles causing eyebrow drooping, vision disturbances, difficulty with mouth movements, facial asymmetry, fatigue, neck pain.

Rare yet serious side effects that can lead to death include but are not limited to: difficulty breathing, swallowing or speaking, spread of toxin affecting areas other than injection site causing muscle weakness in the body, allergic reactions such as itching, rash, wheezing, dizziness or feeling faint. ***Please advise us or seek medical help immediately if any of these reactions occur***

Complications include but are not limited to: under treatment of areas, over treatment of areas, developed immunity to product, resistance to treatment, unsatisfactory results.

You should NOT receive Botox/Xeomin/Dysport/Jeuveau injections if:

- You are pregnant or nursing
- You are ill or taking antibiotics
- You have skin irritation or infection at the planned injection site
- You are allergic to Botox/Xeomin/Dysport/Jeuveau or had a reaction to any other toxin in the past

Please inform us if:

- You have or have a history of any condition that affects your muscles and nerves such as ALS or Lou Gehrig's disease, myasthenia gravis, Lambert-Eaton syndrome, or Bell's palsy
- You have received any toxin product treatment in the past 4 months
- You are taking aspirin or blood thinners

I ,_____have read the above and understand the benefits, effects, and risks involving Botox/ Xeomin/ Dysport/Jeuveau procedures. **I understand these medications have a black box warning, which is required by the FDA, indicating life threatening risks.** By providing my signature I agree to Botox/Xeomin/ Dysport treatment performed by Kimberly Raymond, MD, Sabrina DeVito BSN, RN, or Maryclaire Pennotti, APN,

Date:_____Signature_____Black Box Warning ▫ Witness:_____

Date:_____Signature_____Black Box Warning ▫ Witness:_____

Date:_____Signature_____Black Box Warning ▫ Witness:_____

Date:_____Signature_____Black Box Warning ▫ Witness:_____

General Filler Consent

Injectable dermal fillers are sterile gels, primarily consisting of hyaluronic acid (which is naturally produced in our body) and lidocaine for numbing purposes. Fillers may be used to temporarily restore volume deficit in the face, add volume to areas, soften lines and folds, balance asymmetry in the face and for desired augmentation of facial features. Treatment areas may include lips, cheeks, nose, chin, jawline,nasolabial folds, region around the mouth,marionette lines, or temples. Results can be seen immediately after injection, however, your final result will be about 14 days after injection. Should you require a treatment touch-up, or desire a more dramatic result, you must wait 14 days after your initial injections. There may be an additional charge at your touch-up visit upon provider's discretion.Results of fillers are dependent on which product is used and each individual.

Common side effects include: bleeding at injection site, bruising/swelling/pain/discomfort at and around injection site, redness or skin irritation, tenderness, firmness, lumps/bumps and discoloration.

Complications and risks include but are not limited to: prolonged side effects lasting more than 30 days, resistance to treatment, superficial scarring or development of scar tissue within the layers of the skin, unsatisfactory results and infection.

Rare yet serious risks include:

- **Unintentional injection of filler into a blood vessel. Complications can be serious and permanent**, including but not limited to: vision abnormalities, blindness, stroke, scarring, loss of feeling in area, tissue necrosis. This can happen immediately or within 24 hours of injection. **Please advise us if you have any of the following symptoms: extreme pain in the area, blanching of the skin, abnormally dark purple/blue discoloration in the skin.**

  IN THE EVENT OF A VASCULAR OCCLUSION, HYALURONIDASE, AN ENZYME THAT BREAKS DOWN HYALURONIC ACID MAY NEED TO BE INJECTED. BABY ASPIRIN AND TOPICAL NITROGLYCERIN MAY ALSO BE USED. _____X_____
- **Allergic reactions to filler may include but are not limited to:** itching, rash, wheezing, swelling of the face, mouth and throat, extreme inflammation, dizziness or feeling faint.

You should NOT receive dermal filler injections if:

- You are pregnant or nursing
- You are ill or taking antibiotics
- You have skin irritation or infection at the planned injection site
- You are allergic any of the ingredients in these products or had a reaction to other fillers in the past
- You received any dental work within 2 weeks before injections or plan to within 2 weeks after
- You have received a COVID-19 vaccine within 4 weeks before injections, or plan to within 4 weeks after

Please inform us if:

- You have a history of cold sores ▫
- You have a history of bleeding disorders or are taking aspirin/blood thinners ▫
- You are on immunosuppressive therapy ▫
- You have a history of excessive scarring or pigmentation disorders ▫

I,_____have read the above and understand the benefits, effects, and risks involving dermal filler procedures. By providing my signature I agree to treatment with any of the above filler products, performed by Kimberly Raymond, MD, Sabrina DeVito BSN, RN, Maryclaire Pennotti, APN.

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Date:_____Signature_____ Witness:_____

Date:_____Signature_____ Witness:_____

Date:_____Signature_____ Witness:_____

Social Media Consent Form

Please be aware that we will need to take before and after photos of your procedure/treatment for medical documentation. We would like your permission to use these photos for informational and advertising purposes. Upon your approval, this may include social media platforms such as Instagram, Facebook or Twitter, as well as our office website, clinical staff's personal/work Instagram accounts, and before/after photo books.

*Please read ALL options before signing consent

- ▢ **Yes**, RaymondMD Aesthetics may use my photos.
- ▢ **No**, do not use my photos for any purpose other than chart documentation.

If you allow us to use your photos, please specify the following:

- ▢ **Use photos of the treated area only**
  (only lips, lower face, full face with eyes blocked out)
- ▢ You may use photos of my **entire face.**

Please check which resources we may use your photos on:

- ▢ Instagram/Facebook/Twitter
- ▢ RaymondMD Aesthetics website
- ▢ Before and after photo albums
- ▢ Clinical Staff personal/work IG accounts

Name (Print) :_____

Signature:_____**Date:**_____