H-MD Medical Spa

5025 Gaillardia Corporate Place, Suite C

Oklahoma City, OK 73142

405-463-5700. Fax 405-463-5705

PLEASE PRINT:

Date: _____ Name: _____

E-Mail: _____ Phone number: _____

Address: _____City: _____State:_____ Zip: _____

Date of Birth: _____ Age: _____ Sex: _____ Driver's License Number: _____

Occupation: _____ Employer: _____

Primary Physician: _____ Phone: _____ Last Seen: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about us? (if a friend please list name so he/she can receive credit) _____

Are you using (or used in the past) ____Azelex ____Differin ____Renova ____ Retin A ____ Tretinoin ____ Glycolic

____ Alphahydroxy ____ Accutane

If so, how long? _____ Prescribing doctor: _____

Do you wear sunscreen and how often? _____ What brand? _____

Do you exercise? If so, how often and what type? _____

Do you drink caffeinated beverages? If so, what type and how many glasses/cans a day? _____

Do you smoke or have you ever in the past? _____

Do you drink alcohol? If so, how often? _____

Meds/Vitamins/Supplements	Mg	AM	Noon	PM	Bedtime

List all food/drug/seasonal/cosmetic allergies	What reaction did you have?

Name of pharmacy: _____

Address: _____Phone: _____

Patient Signature: _____ Date: _____

Jennie Hunnewell MD

H-MD MEDICAL SPA

H-MD Cosmetic Surgery and Medical Spa

INFORMED CONSENT FOR TREATMENT

Confidentiality: When a request for services is made to this office, all information is kept confidential and cannot be released without your written permission. We want to let you know that there are special situations in which confidential information could be revealed:

1. Some of your information (name, date of birth, date of admission for services, diagnosis, etc.) This office will only release information about your account (other than described above) when the request is accompanied by your sign consent.
2. A basis for planning your care and treatment with public and/or private schools.
3. A means of communication among medical and mental health professionals who contribute to your care presently or prior.

Fees: The fees charged are determined and agreed upon prior to delivery of services. You will be expected to pay for services at the time they are rendered.

Primary Care: The care provided in this clinic is not intended to replace that of your primary care physician, nor do I admit patients to local hospitals or take emergency call. By signing this consent you are acknowledging that you are aware that you must still receive the usual preventative care (with timing as suggested per community standard) such as pap smear, pelvic exam, mammogram, digital rectal exam or any personal disease-specific care which you are currently undergoing. I am happy to communicate with your primary care physician regarding any care that is provided to you if that is your request, and you are encouraged to communicate that as well.

Appointments: You will be given a definite time for your appointment. Every effort is made to see you at your appointment time and we appreciate your call at least 24 hours in advance if you are unable to keep your appointment or you could incur a $25 missed appointment charge.

Insurance: This clinic does not accept insurance of any kind for payment. We provide a receipt at the time of your service that is ready to be submitted to your insurance company for reimbursement.

Your signature indicates that you have read and understand the preceding information concerning practice procedures, services and confidentiality, insurance and that your consent is given to receive services for yourself and/or your minor child.

Patient Printed Name _____

Patient Signature: _____

Date: _____

PROTECTED HEALTH INFORMATION
AUTHORIZED PERSON(S)

Please print below:

I, _____ hereby authorize release of my Protected Health Information for verbal discussion only of my care and treatment to the person (s) specified below (45CFR, 164.502 [G]):

Authorized family member or person to receive information for the above named patient's care:

Name of Central Contact (other than patient) _____

Relationship to Patient _____

Phone Number _____

Others authorized to receive my verbal information (please list names and relationship)

Print Name _____

Relationship to Patient _____

Phone _____

Note: This form does not give the above referenced persons permission to make health care decisions for the Patient or entitle them to paper copies or electronic access of your medical record. We will not release via the telephone or any other means of communication any information to any friends or family members not listed unless patient has an opportunity to the object and does not documented or if it's reasonable to infer that the patient does not object such as when a patient brings a spouse into the room when treatment is being discussed.

EXCEPTION: IF THE RELEASE IS NEEDED IN EMERGENCY SITUATIONS.

- **May we include you in the clinic or hospital directory? If you are in our clinic seeking treatment and a spouse or other family member calls to inquire if you are still there, can we say? YES _____ NO _____**
- **May we leave message on answering machine or voicemail? We may leave message reminders, scheduling changes or notices that lab results are in on your answering machine. YES _____ NO _____**
- **May we leave you a voicemail for you to return our call? We may leave a message regarding appointment reminders, scheduling changes or notices that lab results are in with the individual who answers the phone? YES _____ NO _____**

NOTE: By signing and dating this Protected Health Information Authorizing Person(s) form, I revoke all previously signed Protected Health Information Authorized Person (s) forms.

Patient Signature: _____ Date: _____

Personal Rep: _____ Relationship to Patient: _____

Note: Except to the extent that action has already been taken in reliance on this Protected Health Information Authorized Person (s), at any time I can revoke this Protected Health Information Authorized Person (s) by submitting a new Protected Health Information Authorized Person (s) form or by written notice.

Consent For Use of Photographic and Video Imagery and Testimonials

Patient Name: _____ Date: _____

Consent for use of photographs, videos and testimonials

I, _____ authorize H-MD Medical Spa to photograph me before, during and after my procedure and to utilize my testimonial. I agree that they may be used for the purposes indicated below. I understand that these photographs, videos and testimonials are the property of Dr. Jennie Hunnewell and will be maintained as part of my medical chart.

I AGREE TO THE FOLLOWING OPTIONS:

_____ So long as my full name is not used or disclosed, my photographs and age at the time of my procedure may be used for education purposes, such as publication in medical journals, or for inclusion in a patient album maintained by H-MD Cosmetic Surgery and Medical Spa. I consent for my photographs, videos and testimonials to be used in H-MD'S social media including but not limited to Facebook, Twitter, Instagram, YouTube, TV marketing, etc.

_____ I give Dr. Jennie Hunnewell consent to promote the services offered by H-MD Medical Spa in advertising publications, marketing materials, publicity, promotion, or consultations with potential patients, including our office brochures with understanding that my FULL NAME WILL NOT BE USED OR DISCLOSED IN CONNECTION WITH THIS IMAGE.

_____ So long as my full name is not used or disclosed, I will give Dr. Jennie Hunnewell/H-MD Medical Spa consent to video record my procedure(s) for educational purposes, such as training, which will only be conducted at Dr. Jennie Hunnewell/H-MD Medical Spa.

_____ I give Dr. Jennie Hunnewell/H-MD Medical Spa to use my first name, photographs, videos along with age at the time of my procedure and voice testimonial quotes for any and all advertising and marketing purposes in such a manner as Dr. Jennie Hunnewell/H-MD Medical Spa deem proper.

_____ I release Dr. Jennie Hunnewell/H-MD Medical Spa from any and all claims which may or could arise from the taking or use of such photographs, videos and testimonials.

____I decline use of my photographs, videos and testimonials to be used for all purposes other than for my personal medical records.

I have read and understand this form. I have had a chance to ask questions about it. Based on this understanding, I consent to the above options as initialed by me. Furthermore, I understand that I will not receive any remuneration now or in the future and I waive any interest in the same. This consent shall remain in effect unless terminated by me in writing.

Patient Signature: _____

Jennie Hunnewell MD
H-MD MEDICAL SPA

Injectable Filler Treatment Informed Consent

I, _____understand that I will be injected with injectable Filler in the following areas: _____
The injectable Filler is a reabsorbable 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 an injectable Filler 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 Filler material collecting in one area. I also understand that I may be able to feel the Filler 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. **Infection:** As with all transcutaneous procedures, I understand that injection of any filler material carries the risk of infection.

4. **History of Herpes Infection:** I understand that there is a risk that injection of any filler material carries the risk of a recurrence of an outbreak of herpes (fever blisters/cold sores/shingles) and that the outbreak may be severe in nature. I have disclosed to the health care provider my medical history and, in particular, disclosed prior herpes outbreaks..

5. **Accidental Injection into a Blood Vessel:** I understand that injectable Filler 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.

6. **Duration of Effect:** I understand that the outcome of treatment with injectable Filler will vary among patients. In some instances, additional treatments may be necessary to achieve the desired outcome.

This above list is not meant to be inclusive of all possible risks associated with Injectable Filler 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.

I have discussed the potential risks and benefits of Injectable Filler with my doctor. I understand that there is no guarantee of any particular results of any treatment.

I understand and agree that all services rendered will be charged directly to me, and I am personally responsible for payment. I further agree, in the event of non-payment, to bear the cost of collection, and/or court costs and reasonable legal fees, should they be required. By signing below, I acknowledge that I have read the foregoing informed consent, have had the opportunity to discuss any questions that I have with my doctor to my satisfaction, and consent to the treatment described above with its associated risks. I understand that I have the right not to consent to this treatment and that my consent is voluntary. I hereby release the doctor, the person performing the Injectable Filler injection and the facility from liability associated with this procedure.

DATE OF TREATMENT:	**PATIENT SIGNATURE:**

Laser Treatment Information and Consent Form

This form is designed to provide you with general descriptions of our various dermatological treatments, including possible risks and benefits that may occur as a result of these treatments. Please read carefully.

General Risks

Proper eyewear must be used by the patient and clinician to dramatically reduce or eliminate eye injury.

Initial Here _____

Possible Risks and Side Effects

Risks and side effects may include pain, redness, swelling (edema), slight burning sensation, herpetic skin eruptions, hair reduction, skin discoloration, scar formation and infection. A topical anesthetic may be applied before treatments to alleviate some of these discomforts. Photographs are also recommended during treatment stages for future comparison. Multiple treatments will be necessary to achieve complete satisfaction.

_____ Initial Here

Procedures

Enhanced Skin Rejuvenation, Wrinkle Reduction, Vascular and Pigmented Lesions

Non-ablative (no body tissue removal) laser treatment is a technique used to improve skin texture and eliminate blemished areas from the skin. It is useful to counteract aging and sun damaged skin. The laser is designed to penetrate the lower layers of the skin without injuring the outer layers. Benefits include: reduction of fine wrinkles, pigmented lesions, solar spots, uneven skin color and small red or blue vessels may be reduced or eliminated.

_____ Initial Here

Permanent Hair Reduction & Pseudofolliculitis

Designed to target or destroy the hair follicle. Benefits include: delayed hair re growth in the treated area, lightening of the hair, decreased density of the hair and long term hair reduction. Multiple treatments will be needed to achieve satisfaction.

_____ Initials

Acne Treatment

Non-ablative laser treatment used to treat acne lesions on any part of the body. The laser penetrates the lower layers of the skin without harming the outer layers to reduce acne. Multiple treatments will be needed to reduce acne and the severity of lesions.

_____ Initials

Date of Treatment:	Area(s) To Be Treated:	Patient Signature:

Jennie Hunnewell MD
H-MD MEDICAL SPA

Chemical Peels Consent Form

Please initial the following:

___ I understand that a "mid-depth chemical peel" may be useful in improving the appearance of the skin, may reduce the appearance of fine lines and wrinkles and diminish pigmentary irregularities.

___ I am undergoing this peel in an effort to improve my skin texture and color. I understand that the results of this treatment vary according to age, condition of skin, sun damage, smoking, climate and so forth. I may achieve some improvement in my fine wrinkles as well, but not guarantee has been made to me regarding my level of improvement from this peel.

___I have received the Post-Peel Treatment sheet as to how to care for my skin prior to and following this procedure and agree to abide by them. I understand that proper sun protection including, but not limited to, the faithful use of broad spectrum UVA-UVB sun block with a minimum of SPF 30 is vital to proper after care and reduction of risks of undesired side effects.

___I understand that there is a small risk of developing: temporary or permanent pigment (color) change in the skin, reactivation of "cold sores" (herpes infections) in patients with a prior history of herpes, flare of acne-like lesions and a slight possibility of scarring and/or infection. I understand I should not "pick" at any scabbing that may result to minimize the potential of scarring or infection.

___I understand that there is a possibility that this procedure may require additional treatments to achieve optimal results.

___Chemical peels may cause 1 or 2 days of mild redness and then 5 to 7 days (10 days with deeper peels and skin nor pre-treated) with areas of flaking or peeling skin. On rare occasions this peel can penetrate deeper in certain areas, causing a crusted scab to form. I understand that if this area is not treated appropriately it could become infected and possibly lead to the formation of a scar. It is my responsibility to follow the post care instructions and contact Dr. Hunnewell's office if such complications occur.

___I am NOT: allergic to salicylates (i.e. aspirin), pregnant or lactating.

___I agree to having photographs taken of my skin for use either in teaching or to evaluate treatment effectiveness. No photographs revealing my identity will be used without my written consent. If my identity is not revealed, these photographs may be used and displayed publicly without my permission.

___I am NOT currently using Accutane and have NOT used in the last 6 months.

___ I have NOT used Retin-A/Retinoids, AHA (alpha-hydroxy), BHA (beta-hydroxy) or other topical exfoliants 3-4 days prior to this treatment and will NOT use for the next 7 days post-peel.

___I understand that when the chemical peel solution is applied a warming heat sensation will occur temporarily but will subside. I will be provided a hand-held cooling device to help alleviate some of the discomfort associated with the chemical peel solution.

By my signature below, I acknowledge that I read "Chemical Peel Consent Form" and I understand it. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction. I have been adequately informed of the risks, benefits and alternatives to this treatment and wish to proceed with the chemical peel. I will be given post-peel instructions to take home.

Client's Signature _____

Print Signature _____

Date _____

Botox (Botulinum A Toxin) INFORMED CONSENT

I, _____, understand that I will be injected with Botulinum A Toxin (Botox) in the area of the glabella muscles to paralyze these muscles temporarily or in the forehead or crows feet around the lateral area of the eyes.

Botulinum A Toxin (Botox) injection has been FDA approved for use in the cosmetic treatment for glabellar frown lines only – the wrinkles between the eyebrows.

Injection of Botox into the small muscles between the brows causes those specific muscles to halt their function (to be paralyzed), thereby improving the appearance of the wrinkles. I understand the goal is to decrease the wrinkles in the treated areas. This paralysis is temporary, and re-injection is necessary within three to four months. It has been explained to me that other temporary and more permanent treatments are available.

The possible side effects of Botox include, but are not limited to:

1. **Risks: I understand there is a risk of swelling, rash, headache, local numbness, pain at the injection site, bruising, respiratory problems and allergic reaction.**
2. **Infection: Infections can occur which in most cases are easily treatable, but in rare cases a permanent scarring in the area can occur.**
3. **Most people have lightly swollen pinkish bumps where the injections went in, for a couple of hours or even days.**
4. **Although many people with chronic headaches or migraines often get relief from Botox, a small percent of patients get headaches following treatment with Botox, for the first day. In a very small percentage of patients these headaches can persist for several days to weeks.**
5. **Local numbness, rash, pain at the injection site, flu like symptoms with mild fever, back pain.**
6. **Respiratory problems such as bronchitis or sinusitis, nausea, dizziness, and tightness or irritation of the skin.**
7. **Bruising is possible anytime you inject a needle into the skin. This bruising can last for several days, weeks, months and in rare cases the effect of bruising could be permanent.**
8. **While local weakness of the injected muscles is representative of the expected pharmacological action of Botox, weakness of adjacent muscles may occur as a result of the spread of the toxin.**
9. **Treatments: I understand more than one injection may be needed to achieve a satisfactory result.**
10. **Another risk when injecting Botox around the eyes included corneal exposure because people may not be able to blink the eyelids as often as they should to protect the eye. This inability to protect the eye has been associated with damage to the eye as impaired vision, or double vision, which is usually temporary. This reduced blinking has been associated with corneal ulcerations. There are medications that can help lift the eyelid, however, if the drooping is too great the drops are not that effective. These side effects can last for several weeks or longer. This occurs in 2-5 percent of patients.**
11. **I will follow all aftercare instructions as it is crucial I do so for healing.**

As Botox is not an exact science, there might be uneven appearance of the face with some muscles more affected by the Botox than others. In most cases this uneven appearance can be corrected by injecting Botox in the same or nearby muscles. However in some cases this uneven appearance can persist for several weeks or months.

This list is not meant to be inclusive of all possible risks associated with Botox as there are both known and unknown side effects associated with many medication or procedure.

Botox should not be administered to a pregnant or nursing woman.

Additionally,

The number of units injected is an estimate of the amount of Botox required to paralyze the muscles. I understand there is no guarantee of results of any treatment. I understand the regular charge applies to all subsequent treatments.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or Court cost and reasonable legal fees, should this be required.

By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. I hereby give consent to perform this and all subsequent Botox treatments with the above understood. I hereby release the doctor, the person injecting the Botox and the facility from liability associated with this procedure.

Date of Procedure:	Patient Signature: