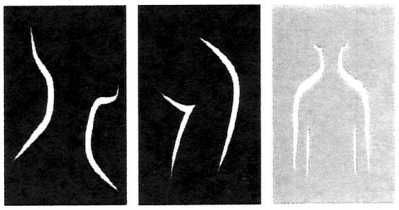
Aline Fournier D.O



Date:_____

Name:_____DOB:_____

Address:_____City:_____State:_____Zip:_____

Email:_____Home/Cell:_____

Employer:_____Work:_____

Emergency Contact:_____Relation:_____Phone:_____

How did you hear about us?_____

Medications

Please list any/add medications or supplements you are currently taking:_____

_____

Are you currently taking any medications for high blood pressure? ____Yes ____No If yes, what is the name of the blood pressure medication you are taking:_____

Are you taking aspirin or any type of blood thinner?_____

____Retin-A ____Differin ____Hydroquinone ____Renova ____Accutane (in the last 6 months)

Other Skin Care Medications/Topical Agents:_____

Allergies

Please list and/all medication allergies:_____

Are you allergic to Latex? ____Yes ____No

Are you allergic to Iodine____Yes____No

Condition

Are you pregnant or plan on becoming pregnant?____Yes____No Are you currently breastfeeding? ____Yes ____No

Do you wear contact lenses? ____Yes ____No Do you have metal implants? ____Yes ____No

Please check all that apply:

____Alcoholism ____Anemia ____Anorexia ____Asthma ____Autoimmune Disease ____Fibromyalgia ____Hepatitis

____Herpes/Cold Sores ____HIV/Aids ____History of Keyloid Scarring ____Bleeding Disorder ____Breast Lump

____Cancer ____Connective Tissue Disorder ____Chemical Dependency ____Migraines ____Multiple Sclerosis

____Neuromuscular Disease ____Pacemaker/Defibrilltor ____Ploycystic Ovaries ____Chronic Fatigue ____Diabetes

____Eating Disorders ____Epilepsy ____Pigmentation Disorder ____Seizures ____Skin Lesion

Skin Care

What is your daily skin regimen?_____

_____

Sun History and Lifestyle

How often are you outdoors? ____Frequently ____Occasionally ____Very Rarely

Is there a family history of skin cancer? ____Yes ____No If so, who? _____

How often do you use sunscreen? ____Frequently ____Occasionally ____Very rarely

How often do you use tanning beds? ____Frequently ____Occasionally ____Very Rarely

Which of the following best describes your skin type?

____Very oily, large pores ____Dry Skin ____Sensitive Skin ____Oily Skin

____Combination skin, oily T-Zone with dry to normal cheeks

Concerns/Interests

____Hair Removal ____Acne ____Rosacea ____Dryness ____Fine Lines ____Wrinkles ____Pore Size

____Discoloration ____Loss of Skin Tone ____Pigmentation ____Brown Spots ____Broken Capillaries/Veins

Other_____

Previous Procedures

Which of the following have you had in the past?

____Botox ____Juvederm ____Radiesse ____Restalyne ____Other Injectables:_____

____Microdermabrasion ____Chemical Peels ____Electrolysis ____Waxing ____Laser Hair Removal

Client Signature:_____Date:_____

Review by:_____Date:_____

PDO THREADS PROCEDURE CONSENT FORM

I understand that:

1. The PDO Threads procedure (the "Treatment") requires small insertions around the area to be treated.
2. The administration of topical anesthesia, local anesthesia or both may be used during the Treatment if deemed necessary by the treating physician .
3. The benefits and results with the Treatment will vary from patient to patient. The results of the Treatment are not guaranteed and will vary due to variables such as: age, condition of my skin, sun damage, climate, smoking, my own biological response to the Treatment, etc.
4. I have discussed alternative treatment options available to me. I understand that this treatment is cosmetic and that there are alternative treatments available for wrinkles and for face-lifts.
5. There are risks related to the Treatment. Unpredictable side effects or complications may occur and can include but are not limited to the following:
    a. Discomfort: during and after the Treatment, such as slight tightening sensation as new collagen is produced in and around the threads.
    b. Bruising: occasionally a small blood vessel may rupture, resulting in a superficial bruise.
    c. Swelling and redness: may result following the procedure due to the insertion of the PDO thread during the Treatment causing inflammatory reaction.
    d. Infection: since the Treatment involves insertion of needles, although rare, there is a risk of you developing an infection at the insertion site.
    e. Discoloration: Skin pigmentation changes can sometimes occur at the insertion site(s).
6. I agree to follow Dr. Fournier's aftercare instructions to minimize side effects and maximize results. Extended direct sun exposure is prohibited while I am undergoing the Treatment, and the daily use of **sunscreen SPF 30 or higher** is highly recommended.
7. I agree that I will inform the Dr. Fournier of any medical problems or change in my physical condition which may affect the Treatment.
8. I expressly assume all risks to me associated with the Treatment, and waive any claim which I might otherwise bring against Dr. Fournier as a result of injuries resulting from or relating to my participation in the Treatment.
9. I agree and understand that my Treatment may be terminated at the recommendation of Dr, Fournier.
10. A11 fees paid for the Treatment sha11 not be refundab1e under any circumstance. I understand the the Treatment is strict1y for cosmetic purposes and therefore wi11 not be covered by insurance.

11. I also acknowledge that the procedures performed on me are being recorded and filmed. I voluntarily grant Dr. Aline Fournier, the perpetual non-exclusive, royalty-free right and license to film, take and use photographs and/or digital images of me(collectively "the "Recordings" for use in promotional and/or educational materials. These materials might include printed or electronic publications, websites or other electronic communications. I further agree that my name and identity may be revealed in descriptive text or commentary in connection with the Recordings. I authorize the use of these Recordings without compensation to me. All Recordings, including film, negatives, digital reproductions, shall be the property Dr Aline Fournier. I agree to release and forever discharge Dr. Aline Fournier from any and all claims in law or equity that I, my heirs or personal representatives have or shall have arising out of Recordings.

By my below signature on this consent form, (the "Consent"), I voluntarily acknowledge and certify that: (i) I have thoroughly read and understand the contents of the Consent, (ii) the disclosures listed above were made to me, (iii) I voluntarily give my consent to the Treatment, (iv) *I understand that I am free to withdraw my consent and discontinue participation in the Treatment(s) at any time, (v) this Consent supersedes any previous verbal disclosures, and (vi) no written or implied verbal guarantee, warranty, or assurance has been made to me regarding outcome of the Treatment(s).*

*Patient's Name:*_____

*Patient's signature:*_____

*Date:*_____

Aline G. Fournier, DO
307 So Ivy Street
Escondido, CA. 92025

COVID-19 Emergency Treatment Consent Form

I, _____(patient), consent to receive emergency treatment from Aline Fournier, DO during the Covid-19 outbreak.

I understand there is much to learn about the newly emerged Covid-19 including how is spreads and is transmitted.

I understand that based on what is currently known about Covid-19 the spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts. I understand that close contact can occur from being approximately 6 feet of someone with Covid-19 or by having direct contact with infectious secretions from someone with Covid-19.

I understand that carriers of Covid-19 may not show symptoms but may still be highly contagious.

I understand that due to the unknowns of this virus, the number of other patients that have been in the practice and the nature of procedures performed here, that I have an increased risk of contracting the virus by being in the practice and by receiving treatment in the practice.

I understand that CDC guidelines do not recommend proceeding with any treatment that is non-essential at this time.

I understand that the treatment I am receiving is an emergency because of the underlying infection, pain or conditions that limit my normal day-to-day activities. I confirm I am seeking treatment for a condition that meets these criteria. _____

I understand that the symptoms listed are representative of Covid-19:
Fever, Dry Cough, Shortness of Breath, Persistent pain or pressure in the chest, Bluish lips or face.

I confirm that I do not display or currently have any of the symptoms that are representative of Covid-19, which are listed above. _____

I understand that all travelers from a country or region with widespread ongoing transmission, as outlined by the CDC, should stay home for 14 days to practice social distancing and monitor their health after their arrival.

I confirm that I have not traveled to any of the countries or regions with widespread, ongoing transmission (Level 3 Travel Health Notice) in the past 14 days. _____

I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with Covid-19 in the past 14 days. _____

Patient Name: _____

Signature: _____

Date: _____

Doctor Signature: _____

Date: _____

PDO Thread Treatment Pre and Post Care Instructions

Pre-Instructions for PDO treatments

- Patients are recommended to arrive to their appointment with no makeup. Any make up will be removed prior to treatment.
- Patients taking blood thinning medication (e.g. Aspirin) should consult with their physician if they can stop for 3 days prior to their treatment.
- Blood thinning medications make increase the possibility of bruising. Consult your physician prior to stopping any medication.
- Patients should avoid alcohol prior to treatment.

PDO Post-care Instructions

1. Avoid tanning machines and direct sunlight, and apply SPF 30+ sunblock when going outside
2. You may gently wash your treated area starting from the same day as your procedure, but avoid aggressive rubbing or massaging the face for at least two weeks.
3. Some localized pain and swelling (lumps and bumps) is normal for the first week, if these issues persist please call the office.
4. Avoid opening your mouth too wide for up to 4 weeks, and reschedule any dental appointments for at least two weeks after your treatment
5. Stinging or pulling pain and discomfort are normal, and can be alleviated with over-the-counter Tylenol 500 mg (1-2 tablets every six hours as directed). NSAIDs such as Ibuprofen and Naproxen can be alternated with Tylenol to reduce swelling.
6. Avoid alcohol and anti-coagulant medicines (aspirin, unless prescribed for medical indications) for 7 days. Avoid anticoagulant medications like aspirin (unless prescribed otherwise) and alcohol for a week, as well as blood thinning vitamins such as A, C and E
7. Avoid high and low temperature extremes for at least 10 days
8. Take a break from strenuous exercise for at least a week.
9. Sleep on your back if you received face or neck procedures.
10. Avoid RF or heat-producing devices like cosmetic laser treatments including microneedling for at least 10 weeks.
11. Patient must finish course of antibiotics if prescribed as part of the treatment protocol. If prescribed antibiotics, finish them all