Craig Callen DDS LLC
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(419)756-0188

CONSENT TO XEOMIN (BOTOX) BOTULINUM TOXIN "A"

TREATMENT

PATIENT: ______________________________

DATE OF BIRTH: ______________________________

ADDRESS: ______________________________

____

PHONE: ______________________________

Treatment History

Is this your first Botox treatment ______ Yes __________No

Any previous Botox treatment __________ Date of last treatment ___________

Off label consent given _______________

Informed consent given _______________

Botox is a neurotoxin produced by the bacterium Clostridium A. Botox can relax the muscles on areas of the face and neck which cause wrinkle associated with facial expressions. Treatment with Botox can cause your facial expression lines or wrinkles to essentially disappear. Areas mo: frequently treated are:) glabellar area of frown lines, located between the eyes; b) crow's feet (lateral areas of the eyes and c) forehead wrinkles Botox is diluted to a very controlled solution and when injected into the muscles with a very thin needle, it is almost painless. Clients may feel a slight burning sensation while the solution is being injected. The procedure takes about 15-20 minutes and the results last 3-6 months. With repeated treatments, the results may tend to last longer. Initials _________

RISKS AND COMPLICATIONS

It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1. Post treatment discomfort, swelling, redness, and bruising, 2. Double vision 3. A weakened tear duct 4. Post treatment bacterial, and/or fungal infection requiring further treatment 5. Allergic reaction 6. Minor temporary droop of eyelid(s) approximately 2% of injections, this usually lasts 2-3 weeks 7. Occasional numbness of the forehead lasting up to 2-3 weeks 8. Transient headache and 9. Flu-like symptoms may occur. Initials _______

PHTOGRAPHS

I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentations. Initails _________

PREGNANCY, ALLERGIES & NEUROLOGIC DISEASE

I am not aware that I am pregnant and I am not trying to get pregnant, I am not lactating (nursing). I do not have any significant neurologic disea including but not limited to Myasthenis Gravis, Multiple Sclerosis, Lambert-Eaton Syndrome, Amyotrophic Lateral Sclerosis (ALS) and Parkinsons's. I do not have any allergies to the toxin ingredients, or to human albumin. Initials _________

PAYMENT

I understand that this is an "elective" cosmetic procedure and that payment is my responsibility and is expected at the time of treatment. Initials _________

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time. Initials _________

RESULTS

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I am aware that when small amounts of purified botulinum (BOTOX) are injected into the muscle it causes weakness or paralysis of that muscle. This appears in 2-10 days and usually lasts 3-6 months but can be shorter or longer. In a very small number of individuals, the injection does nc work as satisfactory or for as long as usual and there are some individuals who do not respond at all. I understand that I will not be able to "frowr while the injection is effective but that this will reverse after a period of months at which time re-treatment is appropriate. I understand that I mus stay in the upright posture and that I must not manipulate the area(s) of the injections for the 2 hrs post-injection period. Initials _______

I understand this elective procedure and I hereby voluntarily consent to treatment with Botox injection for Facial Dynamic Wrinkles, TMJ, or Bruxism. The procedure has been fully explained to me. I have read the above and understand it. My questions have been answered satisfactory. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the office immediatelty. I also state that I read and write in English.

Patient Name (Print) ____________________________

Patient Signature ________________________________ Date ___________________

Doctor Name (Print) ____

Witness Signature ______________________________ Date ___________________

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL INFORMATION

Client Name__________________________________ Date ____________

Date of Birth ____________ Age ________ Occupation __________________

Home Address________________________ City__________ State _____ Zip________

Home Phone ____________ Cell Phone____________ Email ______________

What is the best number for you to receive a follow up call this evening? ____________

Emergency Contact Name & Phone ____________________________

How were you referred to us? ______________________________

MEDICAL HISTORY

Are you currently under the care of a physician? YES / NO

If yes, for what?____

Do you have any of the following medical conditions? (Please marke YES or NO to all)

PLEASE CHECK ALL THAT APPLY:	YES	NO		YES	NO
Cancer			Diabetes		
High Blood Pressure			Herpes		
Arthritis			Frequent cold sores		
HIV/AIDS			Keloid scarring		
Skin disease			Skin Lesions		
Seizure Disorder			Hepatitis		
Hormone Imbalance			Thyroid Imbalance		
Blood Clotting Abnormalities			Any active infection		
Heart Conditions					
Are you pregnant or trying to get pregnant?			Are you breastfeeding?		
Are you using contraception?			Birth control pills		
NEUROLOGIC DISEASES:			Parkinson's		
Myasthenia Graves			Multiple Sclerosis (MS)		
Lambert-Eaton Syndrome			Amuotrophic Lateral Sclerosis (ALS)		

What oral prescription medications are you presently taking? ________________

What antibiotics do you use to treat infections? ______________________

Are you presently taking any of the following medication or supplements listed below?

	YES	NO		YES	NO		YES	NO
Aspirin			Blood thinners			Hormones		
Mood altering medication			Anti-depression medication			Vitamin E		
Fish Oil			Omega 3 fatty acids			Ginkgo biloba		
Garlic			Ginger			Cayenne		
Licorice			Flax seed oil			COQ10		

Have you ever had an allergic reaction to the following?

☐Food ☐Animal Protein ☐Aspirin ☐Lidocaine (Anesthetic) ☐Hydrocortisone

☐Eggs ☐Latex ☐Hydroquinone or skin bleaching agents

Others: ______________________________

FACIAL HISTORY

1) What bothers you most about your facial appearance? ______________________

2) What are your expectations for today's visit? ______________________

Do you regularly sun bathe or use tanning salons? __________ How often? __________

What topical medications or creams are you currently using? ☐RetinA ☐Other

(Please list): ______________________________

Have you waxed, tweezed, bleached or used hair removal cream withing the last week? YES / NO

If yes, please specify: ______________________________

Have you ever had botox or dermal fillers? YES / NO

If yes, When were you last treated: ______________________

Any complications? YES / NO If yes, please specify: ______________________

Have you taken any Aspirin, Ibuprophen, Motrin, Tylenol, Fish Oil, Vitamin E, Blood Thinners, Alcoholic Beverages in the last ten days? YES / NO

If yes, what? ______________________________

FACIAL INJURY TRAUMA HISTORY

1) Is there any history of facial surgery? YES / NO

Describe: ______________________________

2) Is there any recent history of trauma to the head or face? YES / NO

Describe: ______________________________

3) Any TMJ problems? Pain Clenching Grinding

Describe: ______________________________

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature ______________________ ______________ *Date* __________

Craig C. Callen, D.D.S. & Associates

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy as a patient. Implementation of HIPAA requirements offcially began on April 14, 2003, While we have followed these policies for years, there have been a few updates that we wanted you to be aware of. This is a shortened version of the HIPAA policy. The full policy is available for your review if you would like.

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 exchange of information within our office. HIPAA provides certain rights and protections to you as the patient. We follow these guidelines and provide you with the quality care you deserve. Additional information is avaliable from the U.S. Department of Health and Human Services. You can find them online at www.hhs.gov

This summarizes our policy here at Craig C. Callen, D.D.S. & Associates.

Patient information will be kept confidential except when it is necessary to provide services or to ensure that all administrative matters related to your care are handled properly. This may include, but not limited to, the sharing of information with other healthcare providers, laboratories, and health insurance companies. Patient information (treatment plans, insurance forms, eob's etc.) may be stored in file cabinets not accessible by patients. Preparing for and during your dental visit such records may be left, at least temporarily, in administrative areas such as the front office, doctors desk, examination room,etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

We send out reminders to our patients. We do this by one or more of the following; e-mail, texting, calling, and sending postcards. We try to make every effort to remind you of your appointment and any treatlment that you need. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative. We also may send out newsletters or special promotions that we are offfering.

You agree to us sending electronic e-referrals to specialists, which include your PHI and x-rays, if needed. We also send electronic claims to your dental insurance, which includes submitting PHI to receive payment for services provided.

You give us permission to remind you to take pre-medication prior to appointmants, if applicable.

You give us permission to call in any prescriptions you may need and share your PHI with the pharmacist.

The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAAA.

You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor, and understand that you have the right to file a complaint. We can help you do this, and you will not be penalized for filing a complaint.

Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services without your permission.

We agree to provide patients with access to their records in accordance with state and federal laws. We may update this policy as needed to better serve the needs of our patients and our practice.

By signing below, I agree that, I have been offered the HIPAA policy, and understand and acknowledge my agreement to the terms set forth in the HIPAA information and consent form and any future update to this policy.

Patient: ______________________________

Signature: ______________________________

Date: ____________

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize Craig C. Callen & Assoc. L.L.C. to disclose your PHI to the following individuals (check all that apply).

Name: ________________________________ **Relationship to Patient:** ________________
Telephone: (_______)________________ **Email:**________________________________
Types of Information: ☐ Appointment Reminders ☐ Results (X-Ray, etc) ☐ Financial ☐ Other: __________
Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: __________

Name: ________________________________ **Relationship to Patient:** ________________
Telephone: (_______)________________ **Email:**________________________________
Types of Information: ☐ Appointment Reminders ☐ Results (X-Ray, etc) ☐ Financial ☐ Other: __________
Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: __________

Name: ________________________________ **Relationship to Patient:** ________________
Telephone: (_______)________________ **Email:**________________________________
Types of Information: ☐ Appointment Reminders ☐ Results (X-Ray, etc) ☐ Financial ☐ Other: __________
Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: __________

☐ **None of the above** **Signature:** ________________________________

Dr. Craig Callen & Associates

552 South Trimble Road

Mansfield, Ohio 44906

DELINQUENT ACCOUNT:

Any delinquent account may be placed with a collection agency if we are unable to work out a financial solution. Accounts placed with a collection agency will be assessed an additional charge up to 1.5% per month. If your account is placed with a collection agency and legal action is initiated, you will be responsible for any amount due, including but not limited to interest, fees, and/or expenses incidental to the principal obligation prior to a judgment being rendered against you.

BROKEN APPOINTMENTS:

When you miss an appointment or change on short notice, it affects many people. The time is reserved just for you. Missed appointments delay your treatment, but it also takes time away from other patients and leads to higher overhead and increased fees. **We request a two day notice of any change.**

Our policy is:

1st broken appointment/short notice change - We will waive our usual $100 missed appointment/late cancellation fee. **We request a two day notice of any change.**

2nd broken appointment/short notice change - A $100 charge will be reflected on your statement and a $100 deposit for reserving your next appointment time.

3rd broken appointment/short notice change - A $100 charge on your statement plus a $100 deposit for reserving your next appointment time. If you are unable to keep this appointment and do not give us at least 2 business days notice you will forfeit this deposit.

Of course, we understand there are legitimate reasons patients have to occasionally miss appointments. Every situation will be weighed on its own merits.

Thank you for understanding our policy and for your consideration.

I/We the undersigned acknowledge and agree to the terms and conditions of Craig C. Callen, D.D.S. & Associates including but not limited to the fees and conditions contained herein.

Patient Signature_______________________ Date_____________________________

Updated 3/2022