

COASTAL SKIN CENTER
LIPODISSOLVE™ PATIENT HISTORY & CONTACT FORM

Name: _____ Gender: Male / Female Age: _____ DOB: _____

Address: _____ City, State, Zip: _____

Home Phone #: _____ Cell #: _____ Work #: _____

Email: _____

Reason for today's visit: _____

What would you like to achieve with this visit? _____

MEDICAL HISTORY:

Do you have a history of blood clots? Yes No

Have you ever suffered a stroke? Yes No

Do you have any allergies? Yes No

Do you have autoimmune disease? Yes No

Are you taking anticoagulates? Yes No

Do you have cancer? Yes No

Do you have liver disease? Yes No

Do you have infections? Yes No

Are you pregnant? Yes No

 If yes, are you breastfeeding? Yes No

If yes on any of the questions above, please give details: _____

Do you suffer from or have a history of:

Blood pressure? Yes No

 If yes, High Low

Diabetes Yes No

Asthma Yes No

Menopause Yes No

Soy Allergy Yes No

Hormone problems Yes No

Anxiety Yes No

Depression Yes No

Thyroid problems Yes No

Cardiac problems Yes No

Circulatory problems Yes No

Easy bruising Yes No

Vitamin B allergy Yes No

Are you taking any medications?

Yes

No

If yes, please give details: _____

Are you taking any supplements or natural remedies? Yes

No

If yes, please give details: _____

Are you allergic to any medication used in this treatment (details given in your consultation)?

Yes

No

If yes, please give details:

Please give a detailed history of any allergies you may have to any medications, or if you have been recommended to avoid certain medications and the reason:

SURGICAL HISTORY Please give details:

OFFICE USE – To be completed by Physician.

Treatment advised: _____

Treatment goals: _____

Height: _____

Weight: _____

Goal Weight: _____

BP: _____

% Body Fat: _____

Total Fat: _____

BMI: _____

Notes/Comments: _____

TREATMENT INSTRUCTIONS

ACKNOWLEDGEMENT FORM

I have read and understand the instructions give to me on the sheet labeled “Pre-treatment Instructions.” I know that I am expected to follow these treatment instructions explicitly, including keeping scheduled appointments. If I need to cancel or reschedule, I understand that it is courteous to those at Coastal Health and Skin Center to call 24 hours prior to my appointment. I understand that adhering to these instructions is essential if I am to experience good results.

Patient Signature _____ Date _____

Witness _____ Date _____

LIPODISSOLVE PRE-TREATMENT INSTRUCTIONS

PATIENT INSTRUCTIONS

1. Please eat a good meal with protein at least 2 hours prior to your treatment.
2. Do not apply lotions, moisturizers or makeup to the areas being treated on day of appointment.
3. If treating buttocks area, you are recommended to bring or wear a G-string or thong type underwear to your treatments.
4. Avoid direct sun exposure, tanning beds, tanning creams, and tanning pills while undergoing procedure beginning 1 week prior and for the entire duration.
5. Do not take ibuprofen (Advil, Motrin), aspirin or vitamin E for 1 week before injection. You may use your doctor's recommended pain medication for any discomfort.
6. Please wear or bring loose fitting clothes to your treatment appointment. There may be some oozing after treatment onto clothing.
7. Please arrive for your appointment 15 minutes early. If you are more than 15 minutes late for your treatment appointment, we may have to reschedule your appoint.

Lipodissolve injections may require repeated treatments to bring desired results.

Coastal Skin Center
37 Commerce Park
Ellsworth, ME 04605
(207) 667-2422

COASTAL SKIN CENTER BILLING POLICY

Cosmetic Consultation Fee: A Physician consultation is \$100.00. Aesthetician consultation is \$25.00. These fees are not billable to insurance companies; therefore, patients who schedule a treatment will have a portion of the consultation fee deducted from their next visit.

Insurance Billable Consultation Fee: The consultation fee for leg veins and certain medical conditions can be submitted to insurance companies and will be billed at a higher level of service. Co-pays, deductibles and any balance that insurance does not cover is the responsibility of the patient. Because we are billing your insurance, we do not deduct any portion of these fees from any further treatments. We do not bill insurance for any other consultations or procedures and no billing codes are available.

Prepayment: 100% prepayment is required for all scheduled procedures at the time they are booked. All payment is due in advance and any extra treatments done at the appointment will be due at the time of service. Credit cards and Care Credit are welcome.

Canceling/Rescheduling Appointments: Please give 48 hours notice to cancel or reschedule an appointment. Failure to show up or “no show” for an appointment, or canceling/rescheduling an appointment less than 24 business hours prior to the appointment, will result in forfeiting the entire prepayment for that visit. Messages left on the answering machine over the weekend for Monday appointments will not negate the penalty. Patients who wish to reschedule a “no show” appointment must prepay any subsequent consultation or treatment visits.

Refund Policy: All prepaid procedures must be completed within 4 weeks of payment, or if the procedure is a series/package it must be started within 4 weeks of payment. If the procedure is not completed, or a series is not started, within the 4-week timeframe, and the patient requests a refund, then a 30% penalty will be charged. There are no refunds on prepaid packages once the treatment has started, however, the credit can be used towards another procedure. All credits must be used within a year, otherwise, they will be forfeited.

Please sign below, to indicate that you understand the above billing policy.

Signature

Date