UNITY Medical Centre
2579 King St E. Hamilton, Ontario L8K 1Y4
Family & Urgent Care | Natural Medicine | Medical Aesthetics

DERMAL FILLER & NEUROTOXIN

CLIENT INFORMATION

Name: _____ Date: _____

Date of birth: _____ Age: _____ Female ☐ Male ☐ Non-Binary ☐

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency Contact: _____

How did you hear about us? _____ Phone Number: _____

Would you like to be added to our email list for news and exclusive offers? ☐ No ☐ Yes

MEDICAL HISTORY

Please mark any of the following conditions you may currently have.

- ☐ Alopecia
- ☐ Blood Thinners
- ☐ Bleeding Disorders
- ☐ Chemotherapy
- ☐ Eczema/Rashes
- ☐ Fillers/ Botox
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Pregnancy
- ☐ Recent Chemical Peel
- ☐ Recent Scar Tiessue
- ☐ Recent Surgery
- ☐ Recent Permanent Makeup
- ☐ Skin Cancer
- ☐ Sunburn
- ☐ Seizures
- ☐ Use of Alpha, Hydroxy Acid
- ☐ Use of Acutane, Renova or Retin-A
- ☐ Ultra-Sensitive Skin
- ☐ Varicoise Veins

Any other condition? _____

If you ticked any boxes, please give further details _____

Do you have any allergies? ☐ No ☐ Yes

If yes, please list all: _____

List all medications you take, including vitamins, herbal supplements, aspirin, hormones and topical:

Are you currently taking blood thinning medication? ☐ No ☐ Yes

If yes, please explain: _____

Are you currently pregnant or trying to get pregnant? ☐ No ☐ Yes

If yes, please explain: _____

Do you have any implants? ☐ No ☐ Yes

If yes, please explain: _____

Have you had any Botox/ Dermal Filler treatments recently? ☐ No ☐ Yes

If yes, please state when & explain: _____

Have you had any adverse reactions to any previous treatment ☐ No ☐ Yes

If yes, please explain: _____

Have you exfoliated or applied any products to your face in the last 24 hours? ☐ No ☐ Yes

If yes, please state which products: _____

Have you had any allergic reactions to any of the following?

☐ Asprin
☐ Neurotoxin
Lidocaine (Anesthetic)
Collagen
☐ Eggs
☐ Hydrocortisone

COSMETIC TREATMENT OR SURGERY HISTORY

☐ Dermal Fillers
☐ Neurotoxins
☐ Other _____

By signing below, you agree to the following:

I have completed this form truthfully and to the best of my knowledge. I agree to waive all liabilities toward my medical members and the employer for any injury or damages incurred due to any falsification of my medical history

_____ Client Name (Printed)

_____ Client Name (signature)

_____ Date

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BOTOX & NEUROTOXIN

CLIENT CONSENT FORM

"Botox" is one of the most familiar brands of botulinum toxin injections. Botulinum toxins are neurotoxins that impact nerves, leading to muscle weakening.
These injections serve both cosmetic and medical purposes. Practitioners administer small quantities of botulinum toxin into specific areas to reduce wrinkles, prevent migraines, and manage a broad spectrum of other health conditions.

Botox works by blocking nerve signals to muscles, resulting in the temporary inability of the injected muscles to contract. This effect typically lasts for about three to four months. The specific muscles that are injected depend on the areas of concern, and it's possible to treat multiple areas during a single session.

RISK & COMPLICATIONS

For every treatment, there are inherent risks involved. It is crucial that you thoroughly comprehend these risks before proceeding with the treatment. While providing a complete medical history can help reduce these risks, there may still be unforeseen complications that may arise. If you have any concerns about these risks, do not hesitate to reach out to your healthcare professional.
The potential risks and complications include:

- ☐ Allergic reaction
- ☐ Infection
- ☐ Eye dryness or tearing
- ☐ Swelling
- ☐ Bruising
- ☐ Skin irritation
- ☐ Scarring of the skin
- ☐ Increased sensitivity
- ☐ Headaches
- ☐ Blurred vision
- ☐ Anaphylaxis

It's essential to consult with a qualified healthcare provider to address any concerns and assess your individual risk factors before undergoing any treatment.

In rare cases, botulinum toxin may extend beyond the intended treatment area, resulting in botulinum-like signs and symptoms. These may include breathing difficulties, trouble swallowing, muscle weakness, and slurred speech. If you experience any of these unusual symptoms following treatment, it is imperative to seek immediate medical attention.

BOTOX & NEUROTOXIN CLIENT CONSENT FORM

CLIENT FULL NAME: _____

Please initial each statement:

_____ During the course of the treatment, despite all precautionary measures taken by the technician, it's important to recognize that there is a possibility of injury. I will not hold the technician responsible for any issues that may arise as a result of undergoing the procedure.

_____ I understand that there are inherent risks associated with botulinum toxin/Botox. If I experience any form of adverse reaction, I will promptly seek medical attention and inform my technician.

_____ It is my responsibility to communicate any concerns I may have to the technician before the procedure.

_____ I understand and agree to follow the aftercare instructions provided by my technician. I am aware that not adhering to the aftercare instructions may impact the achievement of the desired results.

_____ I acknowledge that the product will be injected into the muscles of my face as part of the botulinum/Botox process. The technician performing the procedure will not be held liable for any damages to my skin or me for any reason, especially if I fail to follow aftercare instructions.

_____ I have disclosed all pertinent medical history, and I commit to informing my technician of any changes that may occur in the future.

By signing below, I hereby acknowledge that I have read and understand all the information in this informed consent agreement. I understand that this agreement is legal and binding and will remain in effect for this procedure and all future follow-ups conducted by ÛNITY Medical Centre, and any of their associates. I fully understand the risks and side effects associated with the treatment. I freely assume these risks and release ÛNITY Medical Centre, and any of their associates of all liability.

Client Name (printed)	Client Name (signature)	Date

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DERMAL FILLER

INFORMED CONSENT

A dermal filler is a non-surgical cosmetic treatment used to enhance and restore the youthful appearance of the skin. It typically involves injecting a substance, such as hyaluronic acid or collagen, into specific areas of the face or body to smooth wrinkles, add volume, and improve the overall texture of the skin. Dermal fillers can be used to treat fine lines, deep wrinkles, nasolabial folds, marionette lines, and to add volume to the lips and cheeks. They are also employed for facial contouring and scar correction. The effects of dermal fillers are generally temporary and may last from several months to over a year, depending on the type of filler used. Dermal fillers are administered by trained healthcare professionals and are a popular choice for individuals seeking to rejuvenate their appearance without undergoing invasive surgery.

Dermal fillers typically include substances that are injected into the skin to enhance its appearance and address various cosmetic concerns. The key components of dermal fillers include:

- **Hyaluronic Acid:** This is the most common ingredient in many dermal fillers. Hyaluronic acid is a natural substance found in the body that helps maintain skin hydration and volume. It's used to add moisture and plumpness to the skin, reducing the appearance of wrinkles and fine lines.

- **Collagen:** Some dermal fillers contain collagen, a protein that supports the skin's structure and elasticity. Collagen-based fillers help to restore volume and smooth out lines and wrinkles.

- **Calcium Hydroxylapatite**: This mineral-like compound is used in dermal fillers to provide support and structure to the skin. It's often used for deeper wrinkles and facial contouring.

- **Poly-L-lactic Acid**: This biocompatible and biodegradable synthetic substance stimulates collagen production in the skin. It's used for gradually improving skin texture and treating fine lines and wrinkles.

- **Polymethyl Methacrylate (PMMA)**: Tiny PMMA microspheres are suspended in a gel and used in some dermal fillers. They provide a semi-permanent solution for wrinkles and depressions in the skin.

- **Others:** There are also some specialized dermal fillers that may include different substances depending on the specific brand and type. These may include lidocaine (a local anesthetic) for enhanced comfort during the injection.

RISK & COMPLICATIONS

For every treatment, there are inherent risks involved. It is crucial that you thoroughly comprehend these risks before proceeding with the treatment. While providing a complete medical history can help reduce these risks, there may still be unforeseen complications that may arise. If you have any concerns about these risks, do not hesitate to reach out to your healthcare professional.

The potential risks and complications include:

- ☐ Allergic reaction
- ☐ Infection
- ☐ Eye dryness or tearing
- ☐ Swelling
- ☐ Bruising
- ☐ Skin irritation
- ☐ Scarring of the skin
- ☐ Increased sensitivity
- ☐ Headaches
- ☐ Blurred vision
- ☐ Anaphylaxis

Please initial each statement:

_____ During the course of the treatment, despite all precautionary measures taken by the technician, it's important to recognize that there is a possibility of injury. I will not hold the technician responsible for any issues that may arise as a result of undergoing the procedure.

_____ I understand that there are inherent risks associated with dermal fillers. If I experience any form of adverse reaction, I will promptly seek medical attention and inform my technician.

_____ It is my responsibility to communicate any concerns I may have to the technician before the procedure.

_____ I understand and agree to follow the aftercare instructions provided by my technician. I am aware that not adhering to the aftercare instructions may impact the achievement of the desired results.

_____ I acknowledge that the product will be injected into the muscles of my face as part of the botulinum/Botox process. The technician performing the procedure will not be held liable for any damages to my skin or me for any reason, especially if I fail to follow aftercare instructions.

_____ I have disclosed all pertinent medical history, and I commit to informing my technician of any changes that may occur in the future.

By signing below, I hereby acknowledge that I have read and understand all the information in this informed consent agreement. I understand that this agreement is legal and binding and will remain in effect for this procedure and all future follow-ups conducted by ÜNITY Medical Centre, and any of their associates. I fully understand the risks and side effects associated with the treatment. I freely assume these risks and release ÜNITY Medical Centre and any of their associates of all liability.

Client Name (printed)	Client Name (signature)	Date

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DERMAL FILLER & NEUROTOXIN

CLIENT TREATMENT RECORD

CLIENT INFORMATION:

Name: _____ Date: _____

Date of birth: _____ Age: _____ ☐ Female ☐ Male ☐ Non-Binary

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

DERMAL FILLER

	Product Stickers

BOTOX/ NEUROTOXIN

Neurotoxin Type
Lot #
Expiry Date
Neurotoxin Type
Lot #
Expiry Date
Neurotoxin Type
Lot #
Expiry Date

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CLIENT TREATMENT RECORD

CLIENT INFORMATION:

Name: _____ Date: _____

Date of birth: _____ Age: _____ ☐ Female ☐ Male ☐ Non-Binary

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

DATE	AREA TREATED	DOSE	TREATMENT NOTES	PRICE

UNITY Medical Centre
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DERMAL FILLER & NEUROTOXIN

CLEANING INSPECTION RECORD

CLIENT INFORMATION:

Name: _____ Date: _____

Date of birth: _____ Age: _____ ☐ Female ☐ Male ☐ Non-Binary

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

DATE	AREA / ITEM CLEANED	NOTES	SIGNATURE

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DERMAL FILLER & NEUROTOXIN

CLIENT TREATMENT RECORD

I, _____ hereby grant and authorize _____ I grant the right to capture, modify, edit, reproduce, exhibit, publish, distribute, and utilize any photographs, videos, and/or audio recordings taken of me for lawful promotional purposes. These materials may include, but are not limited to, newspapers, flyers, posters, brochures, advertisements, press kits, websites, social media platforms, and other forms of print and digital communication. I provide this authorization without expecting any payment or other forms of consideration.

This authorization remains in effect indefinitely and applies to all languages, media, formats, and markets, whether currently known or discovered in the future.

I willingly waive any rights to royalties or other compensation arising from or related to the use of these photographs or recordings.

I acknowledge and accept that the materials created through this agreement will be the property of the _____ and will not be returned to me.

I hereby release and discharge the _____ from any liability, claims, or legal actions that may arise, including those made by myself, my heirs, representatives, executors, administrators, or any other individuals acting on my behalf or on behalf of my estate.

By signing below, I confirm that I have thoroughly read and comprehended the entirety of the release agreement stated above.

By signing below, I hereby acknowledge that I have completely read and fully understand the above release agreement

_____	_____	_____
Client Name (Printed)	Client (signature)	Date

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CANCELLATION POLICY

In order to ensure the provision of high-quality care within a reasonable timeframe, we have implemented an appointment and cancellation policy.

As appointments are in high demand, canceling your appointment in advance allows us to offer the time slot to another individual seeking timely care. This policy helps us optimize our appointment availability for all clients.

During the appointment booking process, you will be required to make a _____ deposit, which will be applied as a credit towards your scheduled treatments.

We understand that circumstances may arise requiring you to cancel or reschedule your appointment. To avoid any inconvenience, please notify us at least 24 hours prior to your scheduled appointment. In such cases, your deposit will either be refunded or applied towards a future appointment. However, if you provide less than 24 hours' notice, a _____ cancellation fee will be charged.

Please note that if you arrive more than ____ minutes late for your appointment, it will be considered a no-show and the cancellation fee will be applied.

We are more than happy to address any inquiries or concerns you may have regarding our cancellation policy.

I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by its terms. I agree to pay the cancellation fee in the event of a missed appointment.

Client Name (Printed)	Client (signature)	Date