CHICAGO ANTI-AGING INSTITUTE

Welcome and thank you for choosing **Chicago Anti-Aging Institute**. The following information is necessary for our office to serve you with complete accurate and seamless billing. If you need help, please ask the receptionist.

NEW PATIENT INFORMATION

First Name: _____ MI: _____ Last Name _____ Sex: ❑ M ❑ F

Birth Date: _____ Soc. Sec.# ____ - ____ - _____ Employer: _____

Street Address _____ City_____ State____ Zip_____

Primary Phone Number: (____) _____ - _____ Secondary Phone Number: (____) _____ -_____

Email: _____ **How did you hear about our office?** _____

I prefer my appointment reminders via: ❑ Text ❑ Email ❑ Both

Complete the following information and present your insurance cards with a valid form of photo identification to the receptionist.
**Please inform the front desk if you are here due to a Worker's Injury or Auto Accident

	PRIMARY INSURANCE	SECONDARY INSURANCE
Relation to Insured	❑ Self ❑ Spouse ❑ Child ❑ Other	❑ Self ❑ Spouse ❑ Child ❑ Other
Insured Name		
Insured Birthdate		
Insured Insurance ID#		
Insured Policy#		
Male / Female	❑ Male ❑ Female	❑ Male ❑ Female

WORKMANS' COMPENSATION OR AUTO INSURANCE	ATTORNEY'S INFORMATION
Date of Injury or Accident:	Name:
Insurance Company:	Address:
Insurance Address:	City, State, Zip:
City, State, Zip:	Contact Name:
Adjuster Name:	Phone Number:
Adjuster Phone Number:	File #/ Claim #:
File #/ Claim #:	

GROUPON #	VOUCHER #

Patient's Agreement: I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician(s) of Chicago Anti-Aging Institute to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as needed to process insurance claims by the provider or its agent(s). I fully understand and agree that my insurance policy is an agreement between myself and my insurance carrier and that any claims made by Chicago Anti-Aging Institute on my behalf are made only for my convenience and that I am responsible for all charges of Chicago Anti-Aging Institute, S.C., whether or not they are covered by my insurance. I designate this provider, practice, and agent as Authorized Representative with Durable Power of Attorney in insurance related matters. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. This shall remain in effect until revoked by me in writing. I designate Chicago Anti-Aging Institute and agent(s), to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I received from Chicago Anti-Aging Institute. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care reimbursement and to pursue any other applicable remedies, all in connection expenses as the result of all services incurred. I also hereby give my consent to allow Chicago Anti-Aging Institute to contact me via text and/or email. I understand that charges may apply through my cell phone carrier if I opt to have contact through text. I hereby order all parties to accept a copy of this release and assignment in lieu of the original.

Patient or Guardian's Signature _____ Date _____

Office Use Only- CAAI #:

CHICAGO ANTI-AGING INSTITUTE

BOTOX®-/ JUVEDERM®-FILLER PATIENT INFORMATION AND MEDICAL HISTORY

Name _____ **Date** _____ **CAAI #** _____

HISTORY: Please check if you have or have had any of the following: ❑Sensitive to anesthetic ❑Hypertension ❑Diabetes ❑Irregular Menses ❑Photosensitive Disorder ❑Hepatitis ❑Heart Problems ❑Menopause ❑Autoimmune Disorders (Lupus, Rheumatoid Arthritis) ❑Oral Herpes ❑Hysterectomy

Are you under the care of a physician? _____

Current/Recent medications: _____

Please check if you have or have had any of the following; IF YES, PLEASE EXPLAIN:

Keloid scars	❑Yes	❑No	Explain:
Hives	❑Yes	❑No	Explain:
Skin Cancer	❑Yes	❑No	Explain:
Waxing	❑Yes	❑No	Explain:
Electrolysis	❑Yes	❑No	Explain:
Cold Sores	❑Yes	❑No	Explain:
Hypersensitivity to skin products	❑Yes	❑No	Explain:
Skin Infections	❑Yes	❑No	Explain:
Tanning within the last 6 wks	❑Yes	❑No	Explain:
Use of acne products/drugs	❑Yes	❑No	Explain:
Laser skin resurfacing	❑Yes	❑No	Explain:
Chemical Peels	❑Yes	❑No	Explain:
Photosensitizing substances	❑Yes	❑No	Explain:
Laser work of any type	❑Yes	❑No	Explain:
Allergies of any kind including drugs	❑Yes	❑No	Explain:
Recent flu or viral illness	❑Yes	❑No	Explain:
Previous cosmetic procedures	❑Yes	❑No	Explain:
Recent infections	❑Yes	❑No	Explain:
Any skin disorder (eg. acne, rash, cysts)	❑Yes	❑No	Explain:
Other Medical Illness	❑Yes	❑No	Explain:
Are you pregnant?	❑Yes	❑No	

REQUESTED AREA OF TREATMENT:

BOTOX:

❑Frown Lines (Between the Eyes) ❑Crow's feet
❑Horizontal forehead lines ❑Droopy eyebrow
❑Bridge of nose "bunny lines"

FILLER:

LIP ❑Enhancement ❑Augmentation
❑Nasolabial folds ❑Marionette Lines
❑Vertical lip lines ❑Scar fill-in

Chicago Anti-Aging Institute reserves the right to deny a patient's treatment if requesting and/or compounding filler treatment will create unnatural augmentation/distortion of facial features

I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.

Patient Signature:_____ Date:_____

CHICAGO ANTI-AGING INSTITUTE

INFORMED CONSENT - BOTULINA TOXINS - BOTOX INJECTION

INSTRUCTIONS

This is an informed-consent document which has been prepared to help your doctor inform you concerning BOTOX® (*Botulina* Toxin Type A, Allergan) injection, its risks, and alternative treatments. It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and signed the consent for this procedure as proposed by your doctor and agreed upon by you.

GENERAL INFORMATION

Clostridia botulina bacteria produce a class of chemical compounds known as "toxins". The Botulina Type A Toxin (BOTOX) is processed and purified to produce a sterile product suitable for specific therapeutic uses. Once the diluted toxin is injected, it produces a temporary paralysis (chemodenervation) of muscle by preventing transmission of nerve impulses to muscle. The duration of muscle paralysis generally lasts for approximately three to four months.

BOTOX has been approved to treat certain conditions involving crossed eyes (strabismus), eyelid spasm (blepharospasm), cervical dystonia (spastic muscle disorder with the neck) and motor disorders of the facial nerve (VII cranial nerve). As of April 2002, it has been FDA-approved for the cosmetic treatment of forehead wrinkles caused by specific muscle groups. Other areas of the face and body such as crows feet, wrinkles and neck bands may be treated in an "off-label" fashion. BOTOX has also been used to treat migraine headaches, colorectal disorders, excessive perspiration disorders of the armpit and hands, and musculoskeletal pain disorders.

BOTOX injections are customized for every patient, depending on his or her particular needs. These can be performed in areas involving the eyelid region, forehead, and neck. BOTOX cannot stop the process of aging. It can, however, temporarily diminish the look of wrinkles caused by muscle groups. BOTOX injections may be performed as a singular procedure or as an adjunct to a surgical procedure.

ALTERNATIVE TREATMENTS

Alternative forms of management include not treating the skin wrinkles by any means. Improvement of skin wrinkles may be accomplished by other treatments or alternative types of surgery such as a blepharoplasty, face or brow lift when indicated. Other forms of eyelid surgery may be needed should you have intrinsic disorders affecting the function of the eyelid such as drooping eyelids from muscle problems (eyelid ptosis) or looseness between the eyelid and eyeball (ectropion). Minor skin wrinkling may be improved through chemical skin peels, lasers, injection of filling material, or other skin treatments. Risks and potential complications are associated with alternative forms of medical or surgical treatment.

RISKS of BOTOX (Botulina Type A Toxin) Injections

Every procedure involves a certain amount of risk and it is important that you understand these risks and the possible complications associated with them. In addition, every procedure has limitations. An individual's choice to undergo a surgical procedure is based on the comparison of the risk to potential benefit. Although the majority of patients do not experience these complications, you should discuss each of them with your plastic surgeon to make sure you understand risks, potential complications, limitations, and consequences of BOTOX injections. Additional information concerning BOTOX may be obtained from the package-insert sheets supplied by Allergan.

Incomplete Block: It is possible to not experience a complete block of desired muscles. Additional injections to reach the desired level of block can be performed until the goal is achieved.

Asymmetry: The human face and eyelid region is normally asymmetrical with respect to structural anatomy and function. There can be a variation from one side to the other in terms of the response to BOTOX injections.

Drooping Eyelid (Ptosis): Muscles that raise the eyelid may be affected by BOTOX, should this material migrate downward from other injection areas.

Pain: Discomfort associated with BOTOX injections is usually of short duration.

Migration of BOTOX: BOTOX may migrate from its original injection site to other areas and produce temporary paralysis of other muscle groups or other unintended effects. BOTOX has been reported to cause swallowing problems in patients treated for spastic muscle disorders of the cervical region (cervical dystonia).

Bleeding and Bruising: It is possible, though unusual, to have a bleeding episode from a BOTOX injection. Bruising in soft tissues may occur. Serious bleeding around the eyeball during deeper BOTOX injections for crossed eyes (strabismus) has occurred. Should you develop post-injection bleeding, it may require emergency treatment or surgery. Aspirin, anti-inflammatory medications, platelet inhibitors, anticoagulants, Vitamin E, ginkgo biloba, and other “herbs / homeopathic remedies” may contribute to a greater risk of a bleeding problem. Do not take these for ten days before or after BOTOX injections.

Damage to Deeper Structures: Deeper structures such as nerves, blood vessels, and the eyeball may be damaged during the course of injection. Injury to deeper structures may be temporary or permanent.

Corneal Exposure Problems: Some patients experience difficulties closing their eyelids after BOTOX injections and problems may occur in the cornea due to dryness. Should this rare complication occur, additional treatments, protective eye drops, contact lenses, or surgery may be necessary.

Unknown Risks: The long-term effect of BOTOX on tissue is unknown. The risk and consequences of accidental intravascular injection of BOTOX is unknown and not predictable. There is the possibility that additional risk factors may be discovered.

Dry Eye Problems: Individuals who normally have dry eyes may be advised to use special caution in considering BOTOX injections around the eyelid region.

Double-Vision: Double-vision may be produced if the BOTOX material migrates into the region of muscles that control movements of the eyeball.

Eyelid Ectropion: Abnormal looseness of the lower eyelid can occur following BOTOX injections.

Other Eye Disorders: Functional and irritative disorders of eye structures may rarely occur following BOTOX injections.

Blindness: Blindness is extremely rare after BOTOX injections. However, it can be caused by internal bleeding around the eyeball or needle stick injury. In a period of 10 years of BOTOX administration, complications of blurred vision, retinal vein occlusion, and glaucoma have been reported in three patients. The occurrence of eye problems appears to be very rare.

Allergic Reactions: As with all biologic products, allergic and systemic anaphylactic reactions may occur. Allergic reactions may require additional treatment.

Antibodies to BOTOX: Presence of antibodies to BOTOX may reduce the effectiveness of this material in subsequent injections. The health significance of antibodies to BOTOX is unknown.

Infection: Infection is extremely rare after BOTOX injections. Should an infection occur, additional treatment including antibiotics may be necessary.

Skin Disorders: Skin rash, itching, and swelling may rarely occur following BOTOX injection.

Neuromuscular Disorders: Patients with peripheral motor neuropathic disorders (amyotrophic lateral sclerosis, myasthenia gravis, motor neuropathies) may be at greater risk of clinically significant side effects from BOTOX.

Migraine Headache Disorders: BOTOX has been used to treat forehead muscle groups that are involved with the migraine headache condition. Patients are advised that results of BOTOX treatments for migraine headaches may be variable and improvement in this disorder may not occur following BOTOX treatments.

Unsatisfactory Result: There is the possibility of a poor or inadequate response from BOTOX injections. Additional BOTOX injections may be necessary. Surgical procedures or treatments may be needed to improve skin wrinkles including those caused by muscle activity.

Long-Term Effects: Subsequent alterations in face and eyelid appearance may occur as the result of aging, weight loss, weight gain, sun exposure, pregnancy, menopause, or other circumstances not related to BOTOX injections. BOTOX injections do not arrest the aging process or produce permanent tightening of the eyelid region. Future surgery or other treatments may be necessary.

Pregnancy and Nursing Mothers: Animal reproduction studies have not been performed to determine if BOTOX could produce fetal harm. It is not known if BOTOX can be excreted in human milk. It is not recommended that pregnant women or nursing mothers receive BOTOX treatments.

Drug Interactions: The effect of BOTOX may be potentiated by aminoglycoside antibiotics or other drugs known to interfere with neuromuscular transmission.

GENERAL RISKS

Bleeding: It is possible, though unusual, to experience a bleeding episode during or after surgery. Should post-operative bleeding occur, it may require emergency treatment to drain accumulated blood or you may require a blood transfusion, though such occurrences are rare. Increased activity too soon after surgery can lead to increased chance of bleeding and additional surgery. It is important to follow postoperative instructions and limit exercise and strenuous activity for the instructed time. Do not take any aspirin or anti-inflammatory medications for at least ten days before or after surgery, as this may increase the risk of bleeding. Non-prescription “herbs” and dietary supplements can increase the risk of surgical bleeding. Hematoma can occur at any time, usually in the first three weeks following injury to the operative area. If blood transfusions are necessary to treat blood loss, there is the risk of blood-related infections such as hepatitis and HIV (AIDS). Heparin medications that are used to prevent blood clots in veins can produce bleeding and decreased blood platelets.

Infection: Infection is unusual after surgery. Should an infection occur, additional treatment including antibiotics, hospitalization, or additional surgery may be necessary. It is important to tell your surgeon of any other infections, such as ingrown toenail, insect bite, or urinary tract infection. Remote infections, infections in other parts of the body, may lead to an infection in the operated area.

ADDITIONAL ADVISORIES

Female Patient Information: It is important to inform your plastic surgeon if you use birth control pills, estrogen replacement, or if you suspect you may be pregnant. Many medications including antibiotics may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy.

Mental Health Disorders and Elective Surgery: It is important that all patients seeking to undergo elective surgery have realistic expectations that focus on improvement rather than perfection. Complications or less than satisfactory results are sometimes unavoidable, may require additional surgery and often are stressful. Please openly discuss with your surgeon, prior to surgery, any history that you may have of significant emotional depression or mental health disorders. Although many individuals may benefit psychologically from the results of elective surgery, effects on mental health cannot be accurately predicted.

Sun Exposure – Direct or Tanning Salon: The effects of the sun are damaging to the skin. Exposing the treated areas to sun may result in increased scarring, color changes, and poor healing. Patients who tan, either outdoors or in a salon, should inform their surgeon and either delay treatment, or avoid tanning until the surgeon says it is safe to resume. The damaging effect of sun exposure occurs even with the use of sunblock or clothing coverage.

Medications and Herbal Dietary Supplements: There are potential adverse reactions that occur as the result of taking over-the-counter, herbal, and/or prescription medications. Aspirin and medications that contain aspirin interfere with clotting and can cause more bleeding. These include non-steroidal anti-inflammatories such as Motrin, Advil, and Alleve. It is very important not to stop drugs that interfere with platelets, such as Plavix, which is used after a stent. It is important if you have had a stent and are taking Plavix that you inform the plastic surgeon. Stopping Plavix may result in a heart attack, stroke and even death. Be sure to check with your physician about any drug interactions that may exist with medications which you are already taking. If you have an adverse reaction, stop the drugs immediately and call your plastic surgeon for further instructions. If the reaction is severe, go immediately to the nearest emergency room. When taking the prescribed pain medications after surgery, realize that they can affect your thought process and coordination. Do not drive, do not operate complex equipment, do not make any important decisions and do not drink any alcohol while taking these medications. Be sure to take your prescribed medication only as directed.

Travel Plans: Any surgery holds the risk of complications that may delay healing and delay your return to normal life. Please let the surgeon know of any travel plans, important commitments already scheduled or planned, or time demands that are important to you, so that appropriate timing of surgery can occur. There are no guarantees that you will be able to resume all activities in the desired time frame.

Off-Label FDA Issues: There are many devices, medications and injectable fillers and botulinum toxins that are approved for specific use by the FDA, but this proposed use is “Off-Label”, that is not specifically approved by the FDA. It is important that you understand this proposed use is not experimental and your physician believes it to be safe and effective. Examples of commonly accepted “Off-Label” use of drugs or devices include the use of aspirin for prevention of heart disease, retinoids for skin care, and injection of botulinum toxin for wrinkles around the eyes. Botox® is approved for Glabellar frown lines, Blepharospasm, and would be Off-Label for all other uses. I acknowledge that I have been informed about the Off-Label FDA status of Botox®, and I understand it is not experimental and accept its use.

HEALTH INSURANCE

Most health insurance companies exclude coverage for cosmetic surgical operations or any resulting complications. Please carefully review your health insurance subscriber-information pamphlet. **Most insurance plans exclude coverage for secondary or revisionary** surgery due to complications of cosmetic surgery.

ADDITIONAL TREATMENT NECESSARY

There are many variable conditions in addition to risk and potential complications that may influence the long term result of BOTOX injections. Even though risks and complications occur infrequently, the risks cited are the ones that are particularly associated with BOTOX injections. Other complications and risks can occur but are even more uncommon. Should complications occur, additional surgery or other treatments may be necessary.

The practice of medicine and surgery is not an exact science. Although good results are expected, there is no guarantee or warranty expressed or implied, on the results that may be obtained.

FINANCIAL RESPONSIBILITIES

The cost of BOTOX injection may involve several charges. This includes the professional fee for the injections, follow-up visits to monitor the effectiveness of the treatment, and the cost of the BOTOX material itself. It is unlikely that BOTOX injections to treat cosmetic problems would be covered by your health insurance. The fees charged for this procedure do not include any potential future costs for additional procedures that you elect to have or require in order to revise, optimize, or complete your outcome. Additional costs may occur should complications develop from the injections and will also be your responsibility. **In signing the consent for this surgery/procedure, you acknowledge that you have been informed about its risks and consequences and accept responsibility for the clinical decisions that were made along with the financial costs of all future treatments.**

I understand and unconditionally and irrevocably accept this.

DISCLAIMER

Informed-consent documents are used to communicate information about the proposed surgical treatment of a disease or condition along with disclosure of risks and alternative forms of treatment(s), including no surgery. The informed-consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances.

However, informed-consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your plastic surgeon may provide you with additional or different information which is based on all the facts in your particular case and the current state of medical knowledge.

Informed-consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

It is important that you read the above information carefully and have all of your questions answered before signing the consent on the next page.

CONSENT FOR SURGERY/ PROCEDURE or TREATMENT

I hereby authorize the physicians of Chicago Anti-Aging Institute and such assistants as may be selected to perform the following procedure or treatment**: BOTOX INJECTION** (list the anatomic areas where BOTOX will be injected i.e. frontalis and corrugator muscles) I have received the following information sheet**:**

INFORMED CONSENT – BOTOX INJECTION

I recognize that during the course of the procedure and medical treatment or anesthesia, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above physician and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician at the time the procedure is begun.

I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involve risk and the possibility of complications, injury, and sometimes death.

I understand what my surgeon can and cannot do, and I understand there are no warranties or guarantees, implied or specific about my outcome. I have had the opportunity to explain my goals and understand which desired outcomes are realistic and which are not. All of my questions have been answered, and I understand the inherent (specific) risks of the procedures I seek, as well as those additional risks and complications, benefits, and alternatives. Understanding all of this, I elect to proceed.

I consent to be photographed or televised before, during, and after the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures.
For purposes of advancing medical education, I consent to the admittance of observers to the treatment room.

I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical device registration, if applicable.

I understand that the surgeon's fees are separate from the anesthesia and hospital charges, and the fees are agreeable to me. If a secondary procedure is necessary, further expenditure will be required.

I realize that not having the operation is an option.

IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND: THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-10). I AM SATISFIED WITH THE EXPLANATION.

Patient or Person Authorized to Sign for Patient	**Date**
Witness	**Date**

CHICAGO ANTI-AGING INSTITUTE

INFORMED CONSENT - JUVEDERM INJECTION

INSTRUCTIONS
This is an informed-consent document which has been prepared to help us inform you concerning Juvederm® (Non-Animal Stabilized Hyaluronic Acid, Allergan) tissue filler injection therapy, its risks, and alternative treatments. It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent for this procedure.

INTRODUCTION
Juvederm is a stabilized hyaluronic acid used to smooth moderate to severe facial wrinkles and folds around the nose and mouth or shape facial contours. Juvederm has been FDA approved for the cosmetic treatment of moderate to severe facial wrinkles and soft tissue depressions.

Hyaluronic acid is a naturally occurring substance that is found within all mammals. It is a material that is contained in various soft tissues. Hyaluronic acid can be synthetically produced from a process of bacterial fermentation, chemically stabilized, and purified for use as injectable soft tissue filler (non-animal, stabilized hyaluronic acid, Allergan). The hyaluronic acid in Juvederm is bio-compatible and is a totally non-animal product; there is little risk of animal-based disease transmission or allergic reaction.

Juvederm injections are customized for every patient, depending on his or her particular needs. These can be performed in areas involving the face and eyelid region, forehead, and lips. Juvederm cannot stop the process of aging. It can however, temporarily diminish the look of wrinkles and soft tissue depressions. Juvederm injections may be performed as a singular procedure, in combination with other treatments such as BOTOX®, or as an adjunct to a surgical procedure. Juvederm injections require regional nerve blocks or local anesthetic injections to diminish discomfort. Soft tissue fillers, including Juvederm, produce temporary swelling, redness, and needle marks, which resolve after a few days' time.

Continuing treatments are necessary in order to maintain the effect of Juvederm over time. Juvederm once injected will be slowly absorbed by the body. The length of effect for Juvederm injections is variable.

ALTERNATIVE TREATMENTS
Alternative forms of management include not treating the skin wrinkles or soft tissue depressions by any means. Improvement of skin wrinkles and soft tissue depressions may be accomplished by other treatments: laser treatments, chemical skin-peels, dermabrasion, or other skin procedures, alternative types of tissue fillers, or surgery such as a blepharoplasty, face or brow lift when indicated. Risks and potential complications are associated with alternative forms of medical or surgical treatment.

RISKS OF JUVEDERM INJECTIONS
Every procedure involves a certain amount of risk and it is important that you understand these risks and the possible complications associated with them. In addition, every procedure has limitations. An individual's choice to undergo this procedure is based on the comparison of the risk to potential benefit. Although the majority of patients do not experience the following, you should discuss each of them with your physician to make sure you understand the risks, potential complications, limitations, and consequences of Juvederm injections. Additional information concerning Juvederm may be obtained from the package-insert sheets supplied by Allergan.

Problems associated with the use of tissue fillers can relate to normal occurrences following tissue filler injections, or potential complications following tissue filler injections, including Juvederm.

Bleeding and Bruising - It is possible, though unusual, to have a bleeding episode from a Juvederm injection or local anesthesia used during the procedure. Bruising in soft tissues may occur. Should you develop post-injection bleeding, it may require emergency treatment or surgery. Aspirin, anti-inflammatory medications, platelet inhibitors, anticoagulants, Vitamin E, ginkgo biloba and other "herbs I homeopathic remedies" may contribute to a greater risk of a bleeding problem. Do not take any of these for seven days before or after Juvederm injections.

Pain - Discomfort associated with Juvederm injections is normal and usually of short duration. Swelling- Swelling (edema) is a normal occurrence following the injections. It decreases after a few days. If swelling is slow to resolve, medical treatment may be necessary.

Erythema (Skin Redness) - Erythema in the skin occurs after injections. It can be present for a few days after the procedure.

Needle Marks - Visible needle marks from the injections occur normally and resolve in a few days.

Acne - Like Skin Eruptions- Acneiform skin eruptions can occur following the injection of tissue fillers. This generally resolves within a few days.

Skin Lumpiness - Lumpiness can occur following the injection of Juvederm. This tends to smooth out over time. In some situations, it may be possible to feel the injected tissue filler material for long periods of time.

Visible Tissue Filler Material - It may be possible to see any type of tissue filler material that was injected in areas where the skin is thin.

Asymmetry - The human face is normally asymmetrical in its appearance and anatomy. It may not be possible to achieve or maintain exact symmetry with tissue filer injections. There can be a variation from one side to the other in terms of the response to Juvederm injection. This may require additional injections.

Skin Sensitivity - Skin rash, itching, tenderness and swelling may occur following Juvederm injections. After treatment, you should minimize exposure of the treated area to excessive sun or UV lamp exposure and extreme cold weather until any initial swelling or redness has gone away. If you are considering laser treatment, chemical skin peeling or any other procedure based on a skin response after Juvederm treatment, or you have recently had such treatments and the skin has not healed completely, there is a possible risk of an inflammatory reaction at the implant site.

Damage to Deeper Structures - Deeper structures such as nerves and blood vessels may be damaged during the course of injection. Injury to deeper structures may be temporary or permanent.

Infection - Although infection following injection of tissue fillers is unusual, bacterial, fungal, and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a tissue filler treatment. This applies to both individuals with a past history of Herpes simplex virus infections and individuals with no known history of Herpes simplex virus infections in the mouth area. Specific medications must be prescribed and taken both prior to and following the treatment procedure in order to suppress an infection from this virus. Should any type of skin infection occur, additional treatment including antibiotics may be necessary.

Skin Necrosis - It is very unusual to experience death of skin and deeper soft tissues after Juvederm injections. Skin necrosis can produce unacceptable scarring. Should this complication occur, additional treatments, or surgery may be necessary.

Allergic Reactions and Hypersensitivity - As with all biologic products, allergic and systemic anaphylactic reactions may occur. Juvederm should not be used in patients with a history of multiple severe allergies, severe allergies manifested by a history of anaphylaxis, or allergies to gram-positive bacterial proteins. Allergic reactions may require additional treatment.

Scarring - Juvederm should not be used in patients with known susceptibility to keloid formation or hypertrophic scarring. The safety of patients has not been studied.

Granulomas - Painful masses in the skin and deeper tissues after a Juvederm injection are extremely rare. Should these occur, additional treatments including surgery may be necessary.

Skin Disorders - Juvederm should not be used in areas with active inflammation or infections (e.g., cysts, pimples, rashes or hives). In rare instances, granuloma or abscess formation, localized necrosis and urticaria have been reported.

Antibodies to Juvederm - Presence of antibodies to hyaluronic acid tissue fillers may reduce the effectiveness of this material or produce a reaction in subsequent injections. The health significance of antibodies to hyaluronic acid tissue fillers is unknown.

Accidental Intra - Arterial Injection - It is extremely rare that during the course of injection, Juvederm could be accidentally injected into arterial structures and produce a blockage of blood flow. This may produce skin necrosis in facial structures or damage blood flow to the eye, resulting in loss of vision. The risk and consequences of accidental intravascular injection of Juvederm is unknown and not predictable.

Under / Over Correction - The injection of soft tissue fillers including Juvederm to correct wrinkles and soft tissue contour deficiencies may not achieve the desired outcome. The amount of correction may be inadequate or excessive. It may not be possible to control the process of injection of tissue fillers due to factors attributable to each patient's situation. If under correction occurs, you may be advised to consider additional injections of tissue filler materials.

Migration of Juvederm - Juvederm may migrate from its original injection site and produce visible fullness in adjacent tissue or other unintended effects.

Drug and Local Anesthetic Reactions - There is the possibility that a systemic reaction could occur from either the local anesthetic or epinephrine used for sensory nerve block anesthesia when tissue filler injections are performed. This would include the possibility of light-headedness, rapid heartbeat (tachycardia), and fainting. Medical treatment of these conditions may be necessary.

Unsatisfactory Result - Juvederm injections alone may not produce an outcome that meets your expectations for improvement in wrinkles or soft tissue depressions. There is the possibility of a poor or inadequate response from Juvederm injection(s). Additional Juvederm injections may be necessary. Surgical procedures or other treatments may be recommended in additional to Juvederm treatments.

Unknown Risks - The long-term effect of Juvederm beyond one year is unknown. The possibility of additional risk factors or complications attributable to the use of Juvederm as a soft tissue filler may be discovered.

Combination of Procedures - In some situations, Botox® injections or other types of tissue filler materials may be used in addition to Juvederm in order to specifically treat areas of the face or to enhance the outcome from tissue filler therapy. The effect of other forms of external skin treatments (laser and other light therapies, microdermabrasion, dermabrasion, or chemical peels) on skin that has been treated with 1s Juvederm unknown.

Pregnancy and Nursing Mothers - Animal reproduction studies have not been performed to determine if Juvederm could produce fetal harm. It is not known if Juvederm or its breakdown products can be excreted in human milk. It is not recommended that pregnant women or nursing mothers receive Juvederm treatments.

Drug Interactions - It is not known if Juvederm reacts with other drugs within the body.

Long-Term Effects - Juvederm injections should not be considered as a permanent treatment for the correction of wrinkles and soft tissue depressions. Over time, the Juvederm material is slowly absorbed by the body and wrinkles or soft tissue depressions will reappear. Continuing Juvederm treatment (injections) is necessary in order to maintain the effect of Juvederm. Subsequent alterations in face and eyelid appearance may occur as the result of aging, weight loss or gain, sun exposure, or other circumstances not related to Juvederm injections. Future surgery or other treatments may be necessary. Juvederm injection does not arrest the aging process or produce permanent tightening of the skin or improvement in wrinkles.

HEALTH INSURANCE
Most health insurance companies exclude coverage for cosmetic surgical procedures and treatments or any complications that might occur from the same.

ADDITIONAL TREATMENT NECESSARY
There are many variable conditions in addition to risk and potential complications that may influence the long-term result of Juvederm injections. Even though risks and complications occur infrequently, the risks cited are the ones that are particularly associated with Juvederm injections. There is no guarantee or warranty expressed or implied, on the results that may be obtained.

FINANCIAL RESPONSIBILITIES
The cost of Juvederm injection may involve several charges. Additional costs of medical treatment would be your responsibility should complications develop from Juvederm injections.

DISCLAIMER
Informed-consent documents are used to communicate information about the proposed surgical treatment of a disease or condition along with disclosure of risks and alternative forms of treatment(s). The informed-consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed-consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Informed-consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

I have read and understand the following Informed Consent Material for my specific procedure:

JUVEDERM
The risks, benefits, and alternatives of the procedure(s) were explained to me. I understand the specific risks in the consent material for my surgery and understand the significant risks of bleeding, infection, blindness, injury to neighboring structures, capsule contracture (if implants involved), lumpiness, asymmetry, pulmonary emboli, deformity, skin loss or necrosis, healing problems, poor scars, loss of sensation(feeling), appearance/psychological changes, unsatisfactory result, need for future revision surgery and anesthesia. I understand the anticipated results and limitations of the surgery procedure(s). I have realistic expectations and realize that there are no guarantees in plastic surgery. The following instructions were explained to me: Pre and Post procedure instructions, DVT prevention instructions, and medications to avoid instructions. I agree to follow all instructions, to follow up as directed, and to notify the office if any problems or questions arise.

IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND: THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (pages 2 – 4).
I AM SATISFIED WITH THE EXPLANATION.

_____ _____
Patient or Person Authorized to Sign for Patient: **Date:**

_____ _____
Witness: **Date:**

CHICAGO ANTI-AGING INSTITUTE

Chicago Anti-Aging Institute, S.C.

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

Chicago Anti-Aging Institute is committed to maintaining the privacy of your protected health information (PHI). PHI includes individually identifiable health information and information that contains enough specific information that it can reasonably be used to identify the individual. This pertains to any information whether in electronic, written or oral form and also includes photographs of an individual as well as DNA samples. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care and to comply with certain legal requirements. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

USES AND DISCLOSURES

Chicago Anti-Aging Institute (hereinafter called "the Practice") may use and/or disclose your PHI without your signed authorization in the following ways:

1. ***Treatment*** – In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for lower back pain may need to know the results of your latest physician examination by this office.

2. ***Payment*** – In order to get paid for services provided to you, the Practice will provide your PHI to appropriate third party payers. The Practice may also need to tell a third party payer about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense. Examples of third party payers would include Medicare and insurance companies.

3. ***Worker's Compensation*** – If you are involved in a Worker's Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Worker's Compensation system.

4. ***Health care Operations*** – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

5. ***De-identified Information*** – Any information that does not contain items that can be used to identify you. For example, if the Practice publishes an article about low back pain, it can include information about the treatment and outcomes of their patients as long as information that would identify those patients (such as their name, social security number, photograph, etc.) was not included.

6. ***Business Associate*** – To a business associate of the Practice if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

7. ***Emergency Situations*** –
    a. For the purpose of obtaining or rendering emergency treatment to you, provided that the Practice attempts to obtain your consent as soon as possible.

    b. To a public or private entity authorized by law or by its character to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

8. ***Public Health Activities*** – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease.

9. ***Abuse, Neglect or Domestic Violence*** – The Practice is required by law to make a disclosure to a government authority if it believes the disclosure is necessary to prevent serious harm.

10. ***When Release is Required by Law –***
    a. Health Oversight Activities – Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

b. Judicial and Administrative Proceeding – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

c. Law enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, if your PHI is the subject of a grand jury subpoena or if the Practice believes that your death is a result of criminal conduct.

d. National Security and Intelligence Activities – The Practice may disclose your PHI in order to provide authorized governmental officials with necessary intelligence information for national security activities and purposes authorized by law.

11. ***Coroner, Medical Examiner or Funeral Director*** – The Practice may disclose your PHI to a coroner, medical examiner or funeral director for the purpose of identifying you or to help them in the performance of their duties.

12. ***Organ, Eye or Tissue Donation*** – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

13. ***Research*** – If the Practice is involved in research activities, your PHI may be used but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.

14. ***Avert a threat to Health or Safety*** – The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

15. ***Specialized Government Functions*** – This refers to disclosures of PHI that relate primarily to military and veteran activity.

16. ***Military and Veterans*** – If you are a member of the armed forces, the Practice may disclose your PHI as required by military command authorities.

17. ***Directory and Sign-In Log*** – At this time, the Practice does use a sign-in log at the reception window.

18. ***Informational Contact*** - The Practice may contact you regarding information about treatment alternatives or other health-related benefits and services by mail addressed to you at the address you have provided.

19. ***Email and the Internet*** – The Practice does not consider the Internet a secure method of communication and therefore, it will not discuss diagnosis, treatment or billing issues relating to a specific individual via the Internet.

    The Practice may respond to general information questions by email. The Practice may use email to inform you of any revisions to this Privacy Notice. It may also, periodically, contact you by email to inform you about events sponsored by the Practice or to send you its email newsletter. The Practice considers all email it sends to be both worthwhile and informative, however, at any time you can choose not to receive these emails by contacting the Practice. The Practice maintains privacy contracts with all third party contractors that have access to your email address. The Practice will not sell or distribute your email address to any non-contracted third parties.

20. ***Appointment Reminders & Missed Appointments*** – The Practice may contact you to remind you of a future scheduled appointment or a previously scheduled appointment that you have missed. This will initially be through the contact telephone numbers you have provided to us. Messages left for you will not include any specific information related to your diagnosis or therapy, but may include your name and the time and date of your appointment.
    The following appointment reminders may be used by the Practice:

    a. A postcard mailed to you at the address provided;

    b. Contacting you at home by telephone; if you are not available, the Practice may leave a message on your answering machine, voice mail or with the individual answering the phone.

21. ***Family, Friends and Personal Representatives*** – The Practice may disclose to your family member or other relative, your personal representative (legal guardian or person with a durable power of attorney), a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification of (including identifying or locating) a family member, a personal representative, or another person responsible for your care, your location or general condition or death. However, in both cases, the following conditions will apply:

a. If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

b. If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

22. ***Referral Boards and Thank You Cards*** – The Practice feels it is important to thank individuals when they refer others to our office for treatment. This is done in the following ways:

    a. A referral board located in our reception area lists individuals using only their first name and the first initial of their last name. Unique identifiers such as nicknames and titles will not be used without a signed written authorization.

    b. Thank you cards are sent to the referring individuals home address (or address on file). To protect the privacy of the person referred to our office, we will not include their name on the card.

    c. The Practice will not publish (or put into print) any patient names in our newsletters, general mailings or on our website without a signed authorization.

23. ***Spinal Screenings, Scoliosis Screenings, Lectures, Presentations & Seminars***– The Practice does not maintain any records of PHI collected from people at the above events beyond 30 days after the date of the event unless that person becomes a patient of the Practice. The Practice has no control over information given to the school nurse at a scoliosis screening.

Authorization - Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

You have the right to:

1. Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Contact Person.

2. Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice of what information you want to limit, whether you want to limit the Practice's use and/or disclosure, and to whom you want to limit. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

3. Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Contact Person. The Practice will accommodate all reasonable requests.

4. Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Contact Person at the address below. The Practice charges reasonable fees based on the actual cost of fulfilling the request. The Practice will determine the appropriate charge for providing the requested records and inform the requestor in advance of providing the records. If the requestor agrees to pay the fee in advance, the records will be provided. Otherwise, the records will not be provided, unless the Privacy Officer determines that the charge is burdensome to the requestor. According to Illinois law, the charges may not exceed the following: $20.86 handling fee plus 78 cents each for pages 1-25, 52 cents each for pages 26-50, and 26 cents each for pages 51 to end; plus actual costs for copying of items other than paper records. Double- sided pages will be counted as two pages. The Practice does not have the facilities to copy x-rays. The Practice will allow a patient or their personal representative to sign out x-rays. In certain situations that are defined by law, the Practice may deny your request and you will be sent a written denial notice by mail. If you receive a written denial notice you have the right to have it reviewed.

5. Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Contact Person. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the existing information in your PHI is deemed accurate and complete. The Practice will respond to your request within 60 days of receiving it informing you that either an amendment was made or that it was denied. If you disagree with the Practice's denial, you will have the right to submit a written rebuttal letter stating your disagreement and have this letter added to your record.

6. Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Contact Person. The request must state a time period which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

7. Receive a paper copy of this Privacy Notice as well as updates to it from the Practice upon request to the Practice's Contact Person. You may also view and copy this notice from our website at www.caai.com which will be updated whenever revisions to this notice are made.

8. Complain to the Practice or to the Secretary of the U.S. Department of Health & Human Services if you believe your privacy rights have been violated. To file a complaint with the Practice, you must describe the violation that took place in writing to the Practice's Contact Person. A complaint form is available from the Practice to make this process easier. The Practice will send you a written response to your complaint. The law forbids the Practice from taking retaliatory action against you if you complain. Informing the Practice directly allows it the opportunity to correct the violation and the problems in its policies and procedures that allowed the violation to occur in the first place.

PRACTICE'S REQUIREMENTS

1. When there is a difference between federal and State law, the Practice is required to abide by whichever law maintains a higher level of confidentiality with respect to your medical information, as long as there is no direct conflict to the State law. In Illinois, a specific written authorization is required to disclose or release mental health treatment, alcoholism treatment, drug abuse treatment or HIV/Acquired Immune Deficiency Syndrome (AIDS) information.

2. The Practice:
    a. Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy Practices with respect to your PHI.
    b. Is required to abide by the terms of this Privacy Notice or any update of this notice.
    c. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for any PHI that it maintains.
    d. Will distribute any revised Privacy Notice to you prior to implementation.
    e. Will not retaliate against you for filing a complaint.

PRIVACY CONTACT PERSON & PRIVACY OFFICER

To obtain more information on, or have your questions about your rights answered; you may contact the Practice's Contact Person and Privacy Officer, Loren C. Davis, D.C., by phone at 815-838-7746.

Attn: Contact Person
Chicago Anti-Aging Institute
16622 W. 159th St., Suite 500
Lockport, IL 60441

EFFECTIVE DATE

This Notice is in effect as of 08/24/2020 and replaces all prior versions.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand. By signing below, I also acknowledge that any previous documentation under "Chicago Spine Institute, P.C." still remains true and valid.

Patient's Full Name Printed: Date:

Patient or Personal Representative Signature:

If you are signing as the patient's Personal Representative:

Print name of Personal Representative:

Describe your authority (e.g., Attorney-In-Fact or legal guardian):

**Please note, a parent may sign only if they are also the patient's legal guardian.

Witness Signature:

YOU HAVE A RIGHT TO HAVE A COPY OF THIS PRIVACY NOTICE