Acadiana Women's Health Group

Juliet
Cosmetic Procedure Acknowledgement

Patient Name: _____

Account # _____ Physician _____

Juliet is an elective cosmetic procedure which is not covered by insurance plans. Payment for this procedure is the responsibility of the patient and is required in full at the time of service. We accept cash, check and most major credit cards.

Yes, I understand the Juliet procedure is for cosmetic purposes and will not be filed through my insurance plan. I also understand that the fee for this procedure is non-refundable.

_____ _____

Patient Signature Date

Juliet™
Laser Treatment For Vaginal Health

PATIENT IN-OFFICE SURVEY

Juliet Laser for Vaginal Health

We are evaluating a new treatment for our practice and would appreciate it if you could take a few minutes to answer the following questions so that we can gauge patient interest. Thank you for your time!

POSTPARTUM WOMEN

1 Have you delivered more than one child vaginally? ☐ Yes ☐ No

2 Do you feel your vagina is looser than it used to be? ☐ Yes ☐ No

3 Does this looseness impact your sexual satisfaction or sexual confidence? ☐ Yes ☐ No

4 Do you experience any urine leakage during physical activity or exertion such as when you cough, sneeze, laugh, exercise, etc.? ☐ Yes ☐ No

5 Would you be interested in a simple, painless, in-office non-surgical treatment to tighten your vaginal canal? ☐ Yes ☐ No ☐ Maybe

PERIMENOPAUSAL WOMEN

1 Have you started, are you going through menopause, or are you post menopause?
☐ Started ☐ In Menopause ☐ Post Menopause

2 As a result of menopause, do you suffer from:

A Vaginal dryness ☐ Yes ☐ No ☐ Sometimes

B Burning or itching ☐ Yes ☐ No ☐ Sometimes

C Painful intercourse ☐ Yes ☐ No ☐ Sometimes

3 Do these conditions affect your quality of life? ☐ Yes ☐ No ☐ Sometimes

4 Would you be interested in a simple, painless, in-office, non-surgical laser procedure that can restore vaginal health and treat these conditions? ☐ Yes ☐ No ☐ Maybe

WOMEN OF ALL AGES

1 Are you concerned about the appearance of your external genitalia? ☐ Yes ☐ No ☐ Sometimes

2 Does this concern affect your quality of life or confidence? ☐ Yes ☐ No ☐ Sometimes

3 Would you be interested in a simple, painless, in-office non-surgical treatment to improve the appearance (i.e. color, texture, size, skin laxity) of your vagina or labia area? ☐ Yes ☐ No ☐ Maybe

PERSONAL INFORMATION

NAME: _____ AGE: _____

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Acadiana Women's Health Group

Juliet™ Laser Treatment For Vaginal Health

truSculpt® 3D

HEALTH HISTORY

PERSONAL INFORMATION

DATE: _____

LAST NAME: _____ FIRST: _____ M.I.: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

CELL: _____ EMAIL: _____

DATE OF BIRTH (MONTH/DAY/YEAR): _____ AGE: _____

WHERE DID YOU HEAR ABOUT US: (Please be specific)

- ☐ INTERNET
- ☐ ADVERTISEMENT
- ☐ FACEBOOK
- ☐ INSTAGRAM
- ☐ REFERRAL/FRIEND: _____
- ☐ OTHER: _____

I AM INTERESTED IN: (Please check all that apply)

- ☐ CELLULITE REDUCTION
- ☐ FAT REDUCTION
- ☐ HAIR REMOVAL
- ☐ SKIN TIGHTENING
- ☐ VAGINAL REJUVENATION
- ☐ OTHER, PLEASE SPECIFY_____

MEDICAL HISTORY (Check appropriate box next to any condition for which you have ever been treated)

- ☐ ACNE
- ☐ ARTHRITIS
- ☐ AUTOIMMUNE DISORDER
- ☐ BLOOD DISORDERS
- ☐ CANCER (OR RADIATION THERAPY)
- ☐ DIABETES / DIABETIC NEUROPATHY
- ☐ HERPES (OR COLD SORES)
- ☐ HIRSUTISM
- ☐ VITILIGO
- ☐ KIDNEY DISEASE
- ☐ MELANOMA
- ☐ PORT WINE STAIN
- ☐ PSORIASIS
- ☐ PACEMAKER
- ☐ SHINGLES
- ☐ SKIN PIGMENTATION
- ☐ STEROID OR HORMONAL THERAPY
- ☐ HORMONAL IMBALANCES
- ☐ POLYCYSTIC OVARIAN SYNDROME
- ☐ KELOID SCARS / OTHER SCARS

ADDITIONAL QUESTIONS:

1 ARE YOU CURRENTLY BEING TREATED FOR ANY CONDITIONS NOT LISTED? IF YES, PLEASE SPECIFY.

2 ARE YOU CURRENTLY TAKING ANY MEDICATIONS, INCLUDING HERBAL PREPARATIONS, MEDICAL PATCHES OR ASA? IF YES, PLEASE SPECIFY.

3 DO YOU HAVE ANY ALLERGIES? IF YES, PLEASE SPECIFY.

4 HAVE YOU HAD ANY LASER TREATMENTS? IF YES, PLEASE SPECIFY.

5 WHAT PRODUCTS ARE YOU CURRENTLY USING ON YOUR SKIN?

6 DO YOU HAVE A PACEMAKER? (YES / NO)

7 HAVE YOU EVER BEEN TREATED BY AN ENDOCRINOLOGIST (HORMONE IMBALANCE)? IF SO, PLEASE SPECIFY.

8 DO YOU SUNBATHE OR USE SELF TANNING LOTIONS OR USE TANNING BEDS? IF SO, THEN HOW OFTEN?

9 HAVE YOU EVER HAD GOLD THERAPY (USED FOR RHEUMATOID ARTHRITIS)? (YES / NO)

10 ARE YOU CURRENTLY PREGNANT? (YES / NO)

11 DO YOU HAVE ANY PARTICULAR SKIN SENSITIVITIES? IF SO, PLEASE SPECIFY.

12 DO YOU HAVE ANY TATTOOS OR PERMANENT MAKEUP IN THE AREA TO BE TREATED? IF YES, PLEASE SPECIFY.

PLEASE SIGN BELOW TO INDICATE ALL THE INFORMATION ON THIS FORM IS ACCURATE AND COMPLETE.

SIGNATURE: _____ DATE: _____

Juliet™
Laser Treatment For Vaginal Health

ACADIANA WOMEN'S HEALTH GROUP, APMC

PATIENT INFORMED CONSENT

Juliet Laser for Vaginal Health

I hereby authorize Dr._____ or _____, under Dr. _____'s supervision to perform the Juliet Laser treatment. The Juliet is an Er:YAG 2940 nm laser incorporating a unique treatment protocol delivering two passes to the vaginal area to stimulate collagen and revitalize the vaginal tissue to address symptoms associated vaginal atrophy and vaginal relaxation. The laser can treat the labia and vulvar tissue to improve the appurtenance and dyschromia in vulvar area. It may take multiple treatments to obtain optimal results, and it is possible that the results will be minimal or not help at all. The results may be temporary or permanent and there is no way to predict how long the results will last. Although these devices are effective in most cases, no guarantees can be made.

The procedure may result in the following adverse experiences or risks:

- DISCOMFORT/PAIN – Some discomfort and/ or pain may be experienced during treatment. A topical anesthetic will be applied to your skin before external vaginal treatment. Other forms of anesthesia, or pain management, may also be used.
- PINK DISCHARGE/SPOTTING – Pink discharge or spotting may be present for 3-4 days post-treatment.
- INFECTION – Infection is a possibility whenever the skin surface is disrupted which can lead to scarring. Proper wound care and keeping the treated area clean are important. If signs of infection develop, such as pain, heat, blisters, or surrounding redness, please call our office **337-984-1050**.
- CONTACT/ALLERGIC DERMATITIS OR SKIN SENSITIVITY – Potential increased sensitivity, irritation/itching or allergic reaction of the skin due to skin surface disruption.
- ALLERGY – There is a risk of an allergic reaction to the numbing cream.
- EYE EXPOSURE – Protective eyewear (shields) will be provided to you during the treatment. Failure to wear eye shields during the entire treatment may cause severe and permanent eye damage.

I acknowledge the following points have been discussed with me:

- Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me
- Alternative treatments
- Reasonably anticipated health consequences if the procedure is not performed
- Possible complications/risks involved with the proposed procedure and subsequent healing period
- Instructions to refrain from intercourse for at least 72 hours post-treatment
- Instructions to avoid hot tubs, baths or swimming for a few days post treatment
- Post-treatment care instructions

For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Furthermore, I agree to keep Dr._____ and staff informed should I become pregnant during the course of treatment.

- ☐ I certify that I have received an up-to-date (within 6 months) and normal PAP test and gynecologic exam.
- ☐ I certify that I am not menstruating at the time of treatment.
- ☐ I certify that I do not have any active infections in the treatment area.

Photographic documentation may be taken. I hereby ☐ do ☐ do not authorize the use of my photographs for teaching purposes.

ACKNOWLEDGMENT
BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS INFORMED CONSENT FOR THE JULIET LASER TREATMENT, AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.

Signature-Patient	**Print Name**	**Date**
Signature-Witness	**Print Name**	**Date**

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RECOMMENDED PRE & POST CARE FOR JULIET TREATMENTS

For best results please follow these instructions

BEFORE YOUR TREATMENT:

- Hair in the treatment area should be cleanly shaven
- Notify clinic with any changes to your health history or medications since your last appointment
- Notify clinic of any of the following as treatments should not be performed if you have:
  - Infection in the treatment area
  - Bleeding in the treatment area
  - Active menstruation cycle
- If receiving external treatment, apply prescribed anesthetic cream 40 minutes prior to procedure.

AFTER YOUR TREATMENT:

- Over-the-counter pain medication is recommended if you experience minor pain/discomfort post-treatment
- Refrain from intercourse for at least 72 hours post-treatment
- Pink discharge or spotting may be present for 3-4 days post-treatment
- Avoid hot tubs, baths or swimming for a few days post-treatment
- Ablative treatments to external vagina:
  - Skin will be sensitive for a few days
  - Do not apply skin irritants to the area for a few days
  - Do not shave, wax or use depilatory creams for a few days
  - Apply aloe vera gel to outer vulva for comfort
  - Some crusting in the area for a few days is normal, keep moist with aloe vera gel
  - Avoid sun exposure in the area for a few days
- Notify clinic of any concerns (blistering, excessive redness/swelling, itching, etc.)
- Follow-up appointment should be scheduled for 4 weeks post-treatment.

- Additional instructions: _____

_____

Acadiana Women's Health Group . 4640 Ambassador Caffery Parkway . Lafayette, LA 70508
(337) 984-1050 . www.acadianawomens.com

Acadiana Women's Health Group

Juliet™ Laser Treatment For Vaginal Health

truSculpt® 3D

Photo and Video Release Form

I, hereby give my permission to **Acadiana Women's Health Group** and their employees, or any person, firm or organization that they may designate to take photographs, digital images and/or videos of me (**patient name**) _____ or if applicable my (**son/daughter name**) _____ .

This consent includes the use of such photographs, images or videos without my name for procedure evaluation, patient discussion and medical educational purposes regarding the aesthetic procedure. Additional acceptable uses for such images and videos are initialed below.

1. Photo book _____
2. Website or social media sites _____
3. TV broadcast _____
4. Digital/print article or publication _____
5. Advertisement _____

_____ _____

(Patient Name) (Name of Parent/Guardian if applicable)

_____ _____

(Signature) (Date)

_____

(Witness Name)

_____ _____

(Witness Signature) (Date)