Acadiana Women's Health Group

TruSculpt 3D

Cosmetic Procedure Acknowledgement

Patient Name: _____

Account # _____ Physician _____

TruSculpt 3D 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 TruSculpt 3D 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

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: _____

Acadiana Women's Health Group, APMC
337-984-1050

PATIENT INFORMED CONSENT
FOR THE TRUSCULPT PROCEDURE

I hereby authorize Dr._____ or _____, under Dr. _____'s supervision to treat me with the truSculpt device. I understand that this procedure works by using radio frequency (RF) energy to provide uniform deep tissue heating for the purpose of elevating tissue temperature for the treatment of selective medical conditions. There is little or no downtime associated with this treatment. It is possible the result will be minimal or not help at all.

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

- DISCOMFORT AND PAIN – Moderate discomfort or pain during treatment is expected. Mild discomfort or slight tenderness in the treatment area may persist for a few hours following treatment, extending rarely to 24 to 72 hours.
- REDNESS/SWELLING/BRUISING – Short term redness (hyperemia) is expected following treatment and typically persists for several hours. In addition, swelling (edema) and/or bruising of the treated area may occur and typically resolve within 24 hours.
- WOUNDS – Treatment can result in burning, blistering, crusting, scabbing or bleeding of the treated areas. If any of these occur, please call our office **337-984-1050**.
    - INFECTION – Infection is a possibility whenever the skin surface is disrupted, although proper wound care should prevent this. If signs of infection develop, such as pain, heat, or surrounding redness, please call our office **337-984-1050**. It is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff.
    - SCARRING – Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff.
    - SKIN COLOR CHANGES – If the skin surface is disrupted, there is a possibility that the area may become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- NUMBNESS – Temporary numbness may occur, but is rare.
- LUMPS - Firm edemic areas may infrequently develop in the treated area 24 to 72 hours following treatment, and typically resolve without intervention over several weeks.

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 such as surgery
- Reasonable anticipated health consequences if the procedure is not performed.
- Possible complications/risks involved with the proposed procedure and subsequent healing period

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.

Photographic documentation will 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 TRUSCULPT PROCEDURE, AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.

_____	_____	_____
Signature-Patient or Guardian	**Print Name/Relationship**	**Date**
_____	_____	_____
Signature-Witness	**Print Name**	**Date**

Acadiana Women's Health Group

truSculpt 3D

RECOMMENDED PRE & POST CARE FOR truSCULPT 3D TREATMENTS

For best results please follow these instructions

BEFORE YOUR TREATMENT:

- Excess hair may need to be shaved
- Notify clinic with any changes to your health history or medications since your last appointment

AFTER YOUR TREATMENT:

- Tenderness, redness, and swelling may occur and resolve within 24 hours
- Multiple treatments may be required
- Notify clinic if any of the following occur:
    - Blister, crusting, or skin burns
    - Tenderness, redness, or swelling persisting longer than 24 hours
    - Nodules or lumps in the treatment area
        - May develop up to 72 hours 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)