cloud 9 MEDI SPA

CLIENT INFORMATION SHEET

NAME_____DATE OF BIRTH_____

ADDRESS_____CITY:_____

STATE:_____ZIP:_____OCCUPATION:_____

EMAIL:_____REFERRED BY:_____

PHONE:(DAY)_____(NIGHT)_____

PROCEDURES DESIRED: BOTOX: ___FOREHEAD ___CROWS FEET ___FROWN LINES (BETWEEN EYES),OTHER_____

DERMAL FILLERS: ___LIPS ___NASOLABIAL FOLDS ___UNDER EYES ___OTHER

MASSAGE: ___

PERMANENT MAKEUP: ___EYELINER ___EYEBROWS ___LIPLINE ___FULL LIP COLOR ___NIPPLES ___BEAUTY MARK ___SKIN REPIGMENTATION

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? ___YES ___NO

IF SO, WHY?_____PHYSICIAN'S NAME_____

MEDICATIONS:_____ALLERGIES:_____

DO YOU HAVE ANY OF THE FOLLOWING: ___DIABETES ___HEPATITIS ___HEART PROBLEMS ___HEMOPHILIA ___SKIN PROBLEMS

___SCARRING (KELOIDS) ___EYE PROBLEMS ___EPILEPSY ___OTHER & EXPLAIN:_____

ARE YOU PREGNANT OR NURSING? _____ DO YOU WEAR CONTACT LENSES? _____

SIGNED_____DATE_____

PATIENT MEDICAL HISTORY

Patient Name: _____ D.O.B: _____

I. Medical Exclusions

1. Have you had a heart attack within the past 12 months?	☐Yes	☐No
2. Are you currently pregnant?	☐Yes	☐No
3. Are you currently undergoing radiation therapy or chemotherapy for cancer?	☐Yes	☐No
4. Have you had a history of a connective tissue disorder (e.g., Ehlers Danlos Syndrome)?	☐Yes	☐No
5. Do you have severe emphysema or another condition that is oxygen-dependent (e.g., COPD)	☐Yes	☐No

II. Medical History

Please respond to the following conditions:

1. Have you had surgery in the facial area within the previous 9 months?	☐Yes	☐No
2. Limited neck mobility?	☐Yes	☐No
3. Asthma that is inhaler-dependent or other lung problems?	☐Yes	☐No
4. Bleeding disorder?	☐Yes	☐No
5. Abnormal scarring?	☐Yes	☐No
6. Reaction to lidocaine or latex?	☐Yes	☐No
7. Serve dry eyes?	☐Yes	☐No
8. Are you currently taking Coumadin, Plavix or Aspirin on Dr.'s orders?	☐Yes	☐No
9. HIV/AIDS?	☐Yes	☐No
10. Kidney insufficiency?	☐Yes	☐No
11. Liver insufficiency or cirrhosis?	☐Yes	☐No
12. Phlebitis or blood clots?	☐Yes	☐No
13. Diabetes that is not controlled?	☐Yes	☐No
14. Angioplasty with stent placement?	☐Yes	☐No
15. Heart disease or heart problems?	☐Yes	☐No
16. Heart catheterization/stress test?	☐Yes	☐No
Date: _____	☐Normal	☐Abnormal
17. High blood pressure?	☐Yes	☐No
☐High ☐Low ☐Normal 120/80		
18. History of aortic aneurysm?	☐Yes	☐No
19. History of heart attack?	☐Yes	☐No
20. History of stroke?	☐Yes	☐No
21. Do you have a pacemaker?	☐Yes	☐No
22. Angina or chest pain w/ exercise?	☐Yes	☐No
23. Are you a current smoker?	☐Yes	☐No
24. History of seizure disorder?	☐Yes	☐No

III. Anything else we should know?

Please list anything your doctor should know about your health, including and drug allergies, previous surgeries, other medical problems or special concerns:

I certify that I have listed all of my current medications, allergies, hospitalizations, medical conditions and previous surgeries to the best of my knowledge and ability.

_____ _____

Patient Signature Date

INFORMED CONSENT AND RELEASE OF ALL CLAIMS

I CONSENT TO SURGERY OR SPECIAL PROCEDURE
MY SIGNATURE BELOW ACKNOWLEDGES THAT (CROSS OUT ANY STATEMENT THAT IS NOT CORRECT):

I, (Print name) _____authorize **Dr. Jerrel Emery, M.D., Cloud 9 Medi Spa** and or such

Assistants and other Physician(s) as may be designated by him/her, to perform the following surgical or other procedure(s), which

I understand to be:_____

I acknowledge that the nature, purpose and risks/complications of the proposed procedures; alternative methods of medical treatment including risks of such alternatives); and the prognosis if no treatment is received, have been fully explained to me.

1. I understand that in addition to the particular risk of this procedure, there are risks including, but not limited to, blood loss, brain and nerve damage (including paralysis, loss of function and coma), infection, cardiac arrest, and death, which are risks inherent in the performance of any procedure.
2. I understand that during the course of the procedure, unforeseen or unexpected conditions may become apparent that the physician(s) believe would make an extension of the original procedures or a different procedure from that described above advisable to perform. I therefore authorize and request the physician(s) or their designees to perform such procedures as they, in the exercise of their professional judgment, deem reasonable; and I, therefore, waive any obligation on the part of the physician(s) to stop or delay the continuation of the procedure(s) in order to obtain any additional consents.
3. I understand that the facility is a teaching facility and that as deemed appropriate by and under the supervision of the staff physician(s), resident and fellows may assist with or perform all or parts of procedures or other medical acts, and students and others may assist with procedures or medical acts.
4. I am aware the practice of medicine is not an exact science; I acknowledge that no guarantee or assurance has been made to me as to the result that may be obtained from any procedure or treatment.
5. For the purpose of advancing medical education, I consent to the admittance of observers and discussion of my procedures with others who may not be directly responsible for my care.
6. I understand that the physician(s) or others may choose to photograph, televise, videotape or otherwise record all or any portion of my procedure for medical, scientific or educational purposes, I consent to the photographing, televising, videotaping or other forms of recording the procedure(s) to be performed, including appropriate portions of my body functions or sounds, providing my identity is not revealed. I understand and agree that 1) any photographs, films, videotapes, computer data, or other audio or visual recordings created will be the sole property of the facility and will not become part of my medical record; and 2) the facility or any appropriate staff member may edit, preserve, or destroy all or any part of the photographs, films, videotapes, computer data or other audio or visual recordings.
7. I authorize the disposal or retention, preservation, testing, or use for scientific educational or other purposes for all or any portion of specimens, tissues, body parts, or other things, including prosthesis and medical/surgical appliances, that may be removed from my body.
8. I understand that if any medical device defined by federal regulations is implanted in a patient's body, the facility is required by law to report to the manufacturer the name, address and social security numbers of the patient and the description and identity of the device.
9. I so hereby for myself, heirs, executors, administrators, assigns and personal representatives, release, waive and forever discharge including Jerrel Emery,MD personally, Cloud 9 Medical Group., Inc. in Redlands, California, and his office staff, anesthetists, independent contractors, nurses and physicians from any liability, obligations, rights, claims, demands, action or causes of action of cause or character including without limitation, any claims or alleged claims for medical malpractice arising out of or related to surgical procedures.
10. I have carefully read the foregoing release: I understand the contents fully and aware if I have any questions the staff of Jerrel Emery, M.D., Inc. will be more than willing to answer them. I sign this release as my own free act and deed with the intent of being bound by its terms and conditions.

A PHYSICIAN OR PHYSICIAN'S REPRESENTATIVE HAS EXPLAINED TO ME ALL INFORMATION REFERRED TO IN THIS DOCUMENT; I HAVE READ, UNDERSTAND AND AGREE TO THE STATEMENTS SET FORTH IN THIS DOCUMENT (EXCEPT THOSE CROSSED OUT AND INITIALED BY ME); AND ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN BEFORE I SIGNED.

Witness Signature of patient or person authorized to consent for minor or incompetent patient

_____ _____

Date: Relationship to patient if signer is not patient

_____ _____

I have explained the nature, purpose and risks/consequences of the above-described surgery or procedure, alternative methods of treatment (including risks of such alternatives), and the consequences if no treatment is undertaken. No guarantee or assurance has been given by me as to the result that may be obtained.

Signature of physician/ healthcare professional obtaining consent for procedure

Cloud 9 Medical Group, Inc.

Patient/Physician Arbitration Form

1) It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, this arbitration agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use or arbitration.
2) ALL CLAIMS MUST BE ARBITRATED. I understand that all claims for damages arising from medical services rendered by Cloud 9 Medical Group, Inc., or Jerrel Emery, M.D. and/or associate or substitute physicians, nurses or employees must be arbitrated. This includes any claim of a spouse, heir, child (born or unborn), or other successor in interest to any such claim.
3) ARBITRATION PANEL. Within 30 days of a demand to arbitrate a dispute, which must be made in writing, the parties shall agree on three (3) medical arbitrators. Each party will bear the costs for their own legal counsel, and other expenses incurred for their own benefit, as well as pro rata share of arbitration expenses.
4) APPLICABLE LAW. I agree that the California Code of Civil Procedure relating to arbitration shall apply without any exception.
5) REVOCATION OF THE AGREEMENT. This agreement may be revoked and cancelled by written notice delivered to Cloud 9 Medical Group, Inc., and Jerrel Emery, M.D., within 30 days of the signing of this agreement. If notice of revocation of this agreement is not received within 30 days of its signing, the right to cancel the agreement is forever waived.
6) RETROACTIVE EFFECT. If the signing party intends this agreement to cover all services rendered before the date of the signing of this agreement (including, but not limited to, prior consultations or treatment), the signing party must initial here:
7) ACKNOWLEDGEMENT. By signing this agreement, the signing party acknowledges he/she discussed to his/her satisfactory any questions he/she may have had regarding the arbitration agreement with Cloud 9 Medical Group, Inc., Jerrel Emery, M.D., an associate physician, physician assistant, nurse practitioner, or authorized legal representative of Cloud 9 Medical Group, Inc.
8) If any provision of this arbitration agreement should be held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Name:

Patient Signature: Date:

If signed by someone other than the patient, indicate the relationship:

Physician's agreement to arbitrate: In consideration of the foregoing execution of the Patient/Physician Arbitration Agreement, Cloud 9 Medical Group, Inc., Jerrel Emery, M.D., and staff likewise agree to be bound by the terms set forth in this agreement.

PATIENT CONSENT FORM &

NOTICE OF PRIVACY PRACTICES

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining authorization and/or payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operation, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

"I acknowledge that I have received a copy of the Notice of Privacy Practices from Cloud 9 Medical Group, Inc.

Patient Name:_____

Signature:

_____Date:_____

Cloud 9 Medical
Group, Inc. 1174
Nevada Street Suite
150 Redlands Ca
92374 Phone: 909-
792-3223 Fax: 909-
792-3224

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Informed Consent: Injectable Fillers

No medications have been given to me prior to signing this consent form:

Name_____Date_____

This is an informed consent document that has been prepared to help Dr. Jerrel Emery, M.D., inform you about Injectable Fillers, their risks and alternative treatment. It is very important that you carefully and completely read this information. Please read and initial each page and sign the consent form for the treatment as proposed by your surgeon.

Other treatments for soft tissue augmentation of the dermis include bovine-based collagen, fat, calcium hydroxylaptive (Radiesse) and other hyaluronic acid-based dermal fillers(Juvederm, Restylane) Aside from these treatments, additional options for the correction of skin lines and wrinkles do exist. These additional options include Botox cosmetic, different types of facial creams, microdermabrasion, laser skin treatments, and chemical peels, and may be discussed with and by your physician. There are both known and unknown side effects and complications associated with any medication or dermal filler injection procedure. Risks and complications that may be associated with injectable fillers and the implant procedure include, but are not limited to:

Facial Bruising, Redness, Swelling, Itching and Pain

I understand that there is a risk of bruising, redness, swelling, itching, skin discoloration, and pain associated with the procedure. These symptoms are usually mild and typically last less than a week, but can last much longer. Patients who are using medications that can prolong bleeding, such as aspirin or Coumadin, or certain vitamins and supplements, may experience increased bruising or bleeding at the injection site. It is very important that you discuss with your doctor if you are taking any supplements or any medications that can impair your body's ability to clot the blood.

Nodules and palpable material

I understand that there is a risk that lumps may form under my skin due to the filler material collecting in one area. I also understand that I may be able to feel the filler material in the area where the material has been injected. Any foreign material injected into the body may create the possibility of swelling or other local reactions to a filler material.

Migration

I understand that, as with any filler material, Restylane, Radiesse and Juvederm may move from the place where it was injected into another place.

Infection

As with all transcutaneous procedures, I understand that injection of my filler material carries the risk of infection. Caution should be used in patients on immunosuppressive therapy, or therapy used to decrease the body's immune response, as there may be an increased risk of infection. You should inform your doctor if you are immune suppressed in any way.

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Allergic Reactions

I understand that injectable fillers should not be used in patients with severe allergies, a history of anaphylaxis, a history or presence of multiple severe allergies or hypersensitivity to any of the ingredients in injectable fillers, or a history of allergies to Gram-positive bacterial proteins. I understand that it is my responsibility to notify my doctor if I have any of these conditions.

Keloids/ Scarring

I understand that the safety of injectable fillers in patients with known susceptibility to keloid formation or hypertrophic scarring has not been studied, and that having an injectable filler may lead to significant scar tissue or keloid formation and cosmetic deformity.

Skin Breakdown

Although rare, injection into a blood vessel is possible. If that were to happen, it is possible that the skin and soft tissue over that area would breakdown and a large wound could appear. It may take a long time for that area to heal and a large unsightly scar may develop. You may need additional treatment of the wound and scare.

Radio-opacity

I understand that if I have an injection with Radiesse, it is radiopaque and is visible on CT scans and may be visible in x-rays. If additional skin resurfacing treatment such as laser or chemical peel is considered with any type laser treatment, chemical peeling or any other procedure based on active dermal response is considered after treatment with any type of Juvederm injectable gel; there is a possible risk of an inflammatory reaction at the treatment site.

Unsatisfactory Result

I understand that the outcome of treatment with injectable fillers will vary among patients. There is the possibility of a poor result. In some instances, additional treatments may be necessary to achieve the desired outcome. I understand that I will be responsible for the cost of those additional treatments. I also understand that correction is temporary; therefore, touch-up injections as well as repeat injections are usually needed to maintain optimal correction. Having a realistic expectation is important. If you have any concerns, discuss them with your doctor prior to surgery. I also understand that the only recourse that I have for an unsatisfactory result is an additional filler treatment that may be at my own expense. Post-procedure care is an important part of your post-treatment experience. It is your obligation to make sure that you keep all of your follow-up appointments and promptly contact your physician in case of a medical emergency.

I understand that if I seek medical care outside of Cloud 9 Medical Group., Inc., neither Jerrel Emery, M.D., or Cloud 9 Medi Spa are responsible for any expenses incurred.

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I have had sufficient opportunity to discuss this condition and treatment with the doctor and his associates, and all my questions have been answered to my full satisfaction.

I believe that I have adequate knowledge upon which to give an informed consent to the proposed treatment.

I AM AWARE THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND

ACKNOWLEDGE THAT NO GUARANTEES OR PROMISES HAVE BEEN MADE TO ME ABOUT THE RESULTS OF THE PROCEDURE AND THAT RISKS AND COMPLICATIONS, SOME THAT ARE NOT CONTEMPLATED IN THIS FORM, CAN OCCUR. I ALSO UNDERSTAND THAT MY RESULTS AND RECOVERY WILL VARY AND MAY NOT BE SIMILAR TO THE RESULTS AND RECOVERY OF OTHER PATIENTS INCLUDING THOSE DEPICTED IN ADVERTISING.

I ACKNOWLEDGE THAT I HAVE READ ALL THE ABOVE AND ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY FULL SATISFACTION. I ALSO UNDERSTAND THAT I MAY DECIDE NOT TO PROCEED AT THIS TIME. I UNDERSTAND ACCEPT THE RISKS OF THESE AND OTHER POSSIBLE COMPLICATIONS AND CONSEQUENCES ASSOCIATED WITH THIS OPERATION (BE SURE TO ASK YOUR DOCTOR IF YOU HAVE ANY QUESTIONS ABOUT YOUR CARE OR TREATMENT).

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

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

Witness _____

Cloud 9 Medi Spa

1174 Nevada Street Suite 150 Redlands, CA 92374

Phone 909-792-3223

cloud 9

MEDI SPA

BOTOX COSMETIC CONSENT FORM

To the patient: You have the right to be informed about your treatment so that you may make a decision to undergo the procedure, knowing the risks and hazards involved.

I, _____have received a consultation with Dr. Jerrel Emery, M.D., and I consent to having Botox® treatment carried out upon myself

for the improvement of _____.

I understand that I am required to have photographs taken before, during and after treatment for my medical records.
Botox® is injected with a small needle into the muscle, with the aim of inhibiting the underlying muscle contraction, therefore improving facial lines and appearance. It is my understanding that Botox is currently indicated and approved by the Food and Drug Administration(FDA) for cosmetic treatment of the Corrugator muscle complex. I also understand that even though Botox Cosmetic is not currently indicated for the frontalis (forehead muscle) or Orbicularis Oculi muscles (around the outside of the eye), Botox has been extensively reported to be safely used in these areas. As such, I consent to the "off-label" use of Botox in non FDA approved areas of my face, and I take full personal responsibility for any complications that may occur as a result.

I have been informed about the treatment, procedure, indications, expected results and possible side effects. I understand that I may experience swelling, redness, tenderness, slight headache, pain and / or bruising that may occur for several days after my treatment, however these symptoms usually resolve. Rarely an adjacent muscle may be weakened for several weeks after injection. It is also possible that the Botox can migrate into the upper eyelid and cause paralysis of the upper eyelid which can impact my vision and cornea. I also understand that it is possible for the eyebrow to be lowered and to cause asymmetry. I have been advised of the risks involved and the expected benefits of Botox® treatment.

Post marketing reports indicate that the effects of BOTOX and all botulinum toxin products may spread from the area of injection to produce symptoms consistent with botulinum toxin effects. These may include asthenia, generalized muscle weakness, diplopia, ptosis, dysphagia, dysphonia, dysarthria, urinary incontinence and breathing difficulties. These symptoms have been reported hours to weeks after injection. Swallowing and breathing difficulties can be life threatening and there have been reports of death. The risk of symptoms is probably greatest in children treated for spasticity but symptoms can also occur in adults treated for spasticity and other conditions, particularly in those patients who have an underlying condition that would predispose them to these symptoms. In unapproved uses, including spasticity in children, and in approved indications, cases of spread of effect have been reported at doses comparable to those used to treat cervical dystonia and at lower doses. Although the results vary, I have been informed that the practice of medicine is not an exact science and that no guarantees can be or have been made concerning the expected results in my case. I am undergoing treatment of my own free will. I agree that this procedure is being performed for cosmetic reasons and that no guarantee can be made as to the exact results of this procedure. I understand that while every precaution will be taken to prevent complications and that while complications from this procedure are rare, they can and sometimes do occur. I accept responsibility for any and all complications that may occur and thereby absolve Cloud 9 Medical Group, Inc. and Dr.Jerrel Emery, M.D., personally and any associated person of any blame resulting the injection of Botox for cosmetic purposes into different parts of my face.

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I AM AWARE THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND ACKNOWLEDGE THAT NO GUARANTEES OR PROMISES HAVE BEEN MADE TO ME ABOUT THE RESULTS OF THE PROCEDURE AND THAT RISKS AND COMPLICATIONS, SOME THAT ARE NOT CONTEMPLATED IN THIS FORM, CAN OCCUR. I ALSO UNDERSTAND THAT MY RESULTS AND RECOVERY WILL VARY AND MAY NOT BE SIMILAR TO THE RESULTS AND RECOVERY OF OTHER PATIENTS INCLUDING THOSE DEPICTED IN ADVERTISING.

I ACKNOWLEDGE THAT I HAVE READ ALL THE ABOVE AND ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY FULL SATISFACTION. I ALSO UNDERSTAND THAT I MAY DECIDE NOT TO PROCEED AT THIS TIME. I UNDERSTAND ACCEPT THE RISKS OF THESE AND OTHER POSSIBLE COMPLICATIONS AND CONSEQUENCES ASSOCIATED WITH THIS OPERATION (BE SURE TO ASK YOUR DOCTOR IF YOU HAVE ANY QUESTIONS ABOUT YOUR CARE OR TREATMENT).

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

I agree that this constitute full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

I understand that the terms of payment require full settlement on or before the day of my treatment.

Patient Signature_____

Date_____

Witness Signature_____

Date_____

cloud 9 MEDI SPA

1174 Nevada Street Suite 150

Redlands Ca. 92374

BOTOX COSMETIC Patient Instructions

In order to minimize bruising: If possible, please try to avoid alcohol 3 days prior to your procedure.

In order to minimize bruising: Please avoid blood thinning types of pain killers if possible and agreed upon by your

prescribing physician (if applicable): aspirin, aspirin containing products, Motrin, Ibuprofen, Naproxen, Aleve (Please see separate list included), as well as certain herbal supplements.

After your procedure, please continue to apply a cold pack or ice and apply pressure

For the next 4 hours, please AVOID:

1. Please avoid massage around injected area to avoid migration of the Botox product.
2. Please avoid bending over.
3. Please avoid laying down flat
4. Please avoid heavy physical activity.
5. If there is bruising, oftentimes Arnica Montana Gel, cream or oral tab (herbal supplement) will help the bruising resolve faster. Please call our office during normal business hours if you experience any problems.