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evolve

CHIROPRACTIC & WELLNESS CENTRE

MOVE. THRIVE. EVOLVE.

*denotes R Macdonald Professional Corporation

Last Name _____ First Name _____ Who can we thank for the referral? _____

Address _____ City _____ Postal Code _____

Cell Phone _____ Work Phone _____ Emergency Contact _____

Occupation _____ Email (For appointment reminders, Invoices and clinic updates ONLY) _____ I agree

Birthdate (dd/mm/yr) _____ Gender _____ Marital Status _____ Alberta Health Care Number _____

For your convenience and to expedite your check out, we are happy to upload your credit card information to your secure file: *You can remove this information at anytime

Number: _____ - _____ - _____ - _____ Expiry: ____ / ____ CCV: _____

For more information on our policy and security procedures, please don't hesitate to ask our front desk!

EXTENDED HEALTHCARE COVERAGE

Insurance Company Name _____ Group ID/Policy Number _____ Member Number _____

Relationship to Cardholder (self, spouse, child) _____ Name of Cardholder _____

Evolve 5th Avenue

Calgary Place
Suite 116, 414 - 3rd Street SW
Calgary, AB, T2P 1R2

E: 5thAve@evolvechiro.ca
T: 403.474.7792
F: 403.719.0356

Evolve 8th Avenue

Watermark Tower
Suite 110, 530 - 8th Avenue SW
Calgary, AB T2P 3S8

E: 8thAve@evolvechiro.ca
T: 403.474.7792
F: 587.356.1188

Are you pregnant or breastfeeding? ☐Yes ☐No ☐Not yet but plan to be

Reason(s) for visiting us today? Please check off concern(s):

☐ Wrinkles ☐Dropping skin ☐Reduced volume to cheeks/temples/lips
☐Reduced skin elasticity ☐Lines around mouth ☐Dull or dry skin
☐Other (please state): _____

Please check off the treatments or products you have used before:

☐Botox/Dysport
☐Retin A containing products
☐Rosacea or redness reducing creams
☐Mole removal
☐Laser treatment (skin rejuvenation)
☐Laser treatment (hair removal)
☐ Dermal filters
☐ Latisse
☐ Sun protective cream
☐ Skin cancer removal
☐ Laser treatment (pigmentation removal)
☐ Permanent make-up tattoo

Please circle any health issue you have been diagnosed with or have history of:

☐Neurologic disease
☐Stroke
☐Fainting
☐Heart Attacks
☐Blood clotting; bruising/bleeding issues
☐Skin cancer/disease
☐Diabetes
☐Lung/breathing problems
☐ Autoimmune disease
☐ Seizures
☐ Vision Problems
☐ Irregular heart beat
☐ Cardiovascular disease
☐ Face surgery
☐ HIV/Hepatitis/TB
☐ Herpes/cold sores

Have you had a reaction to dental freezing before?

☐Yes ☐No

If "Yes" what was the reaction? _____

Please list any and all Drug/Food/Environmental allergies you are aware of:

_____

Please list all current medications (precription and non-prescription): including OTC, vitamints, herbs and supplements. Please include product name, reason, dose and frequency.

_____

_____

CONSENT AND RELEASE OR RETAIN INFORMATION

I have provided my health information history to the best of my knowledge and give Evolve Chiropractic and Wellness Centre to share my medical information with their Medical Director, my emergency contact or another medical professional in the event my health condition changes during or after treatment.

_____ Initials

I also consent to Evolve Chiropractic and Wellness Centre taking before and after photos of my face for my record. I understand the ohotos may be used for client or medical professional education or promotional purposes without revealing my personal identity

_____Initials

CONSENT FOR USE OF DERMAL FILLERS

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your nurse/healthcare provider. It is important that you fully understand this information, so please read this document throughly. If you have any questions regarding the procedure, ask your nurse/healthcare professional prior to signing the consent form.

_____ Initials

THE TREATMENT

Treatment with dermal fillers (such as Juvederm, Restylane, Revaness, Radiesse and others) can smooth out facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure, illness, etc. Facial rejuvenation can be carried our with minimal complications. These dermal fillers are injected under the skin with a very fine needle or cannula. This produces natural appearing volume under wrinkles and folds which are lifted up and smoothed out. The results can often be seen immediately.

_____ Initials

PREGANCY AND ALLERGIES

I am not aware that I am pregnant. I am not trying to get pregnant. I am not lactating (nursing). I do not have or have not had any major illnesses which would prohibit me from receiving dermal fillers. I certify that i do not have multiple allergies or high sensitivity to the medications, including but not limited to lidocaine.

_____ Initials

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that i have volunteered for have been fully explained to me.

PAYMENT

_____ Initials

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment.

_____ Initials

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time _____ Initials

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use of scientific and marketing purposes both in publications and presentations. I understand that photographs and videos may be taken of me for educational and marketing purpose. I hold Evolve Chiropractic and Wellness harmless for any liability resulting form this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

_____ Initials

RESULTS

Dermal fillers have been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines and folds in the skin on the face. Its effect can last up to 6 months. Most patients are pleased with the results of dermal fillers used. However, like any aesthetic prcedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatment to achieve the results you seek. The dermal filler procedure is temporary and additional treatments will be requires periodically, generally within 4-6 months, involving additional injections for the effect to continue. I am aware that follow-up treatments will be needed to maintain the full effects. I am aware the duration of treatment is dependent on many factors including but not limited to: age, sex, tissue conditions, my general health and lifestyle conditions, and sun exposure. The correction, depending on these factors, may last up to 6 months and in some cases shorter/ longer. I have been instructed in and understand the post-treatment instructions.

I understand this is an elective procedure and i hereby voluntarily consent to treatment with dermal fillers for facial rejuvenation, lip enhancement, establishing proper lip and smile lines, and replacing facial volume. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have red the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I undersant that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the nurse/healthcare professional who treated me immediately.

_____ Initials

CONSENT FOR USE OF NEUROMODULATOR COSMETICS

THE TREATMENT

Botox and Dysport is a brand name of botulinum toxin type A, a neurotoxin that blocks muscles and the nerves that control them. The effects of Botox become apparenty 2-5 days after injection and generally last for 4-6 months. The FDA has approved the use of Botox to treat facial dystonias (spasms), strabismus (crossed eyes), and to temporarily soften facial rhytids (wrinkles) between the eyebrows. While the FDA has not approved injections to improve the appearance of wrinkles in other areas of the face, healthcare providers may perform these "off-label) procedures. There are alternatives to Botox, including no treatment or medicines or surgery on my facial nerves and muscles.

_____ Initials

RISK AND COMPLICATIONS

Include but are not limited to:

1. Bruising
2. Under correction (not enough effect) or over correction (too much effect)
3. Facial asymmetry (one side looks different than the other)
4. Paralysis of a nearby muscle leading to: droppy eyelid, double vision, inability to close eye, difficulty whistling or drinking from a straw
5. Generalized weakness
6. Permanent loss of muscle tone with repeated injection
7. Flul-like syndrome or respiratory injection
8. Nausea or headace
9. Development of antibodies to Botox
10. Botox contains human-derived albumin and carries a theoretic risk of virus transmission. There have been no reports of disease transmission through Botox.

_____ Initials

CONTRAINDICATIONS

You should not have Botox if: you are pregnant; nursing; allergic to albumin; have a infection, skin condition, or muscle weakness at the site of the injection; or have Eaton-Lambert syndrome, Lou Gehrig's disease, or myasthenia gravis.

_____ Initials

RIGHT TO DISCONTINE TREATMENT

I understand that I have the right to discontinue treatment at any time. _____ Initials

UNDERSTANDING OF AGREEMENT

I understand the above, and have had the risks, benefits and alternatives explained to me. No guarantees about results have been made. I give my informed consend for dermal and neuromodulator injections today as well as furture treatments needed.

_____ Initials

Consent to Release Information:

I give Evolve Chiropractic & Wellness Center my consent to release/obtain information from the following individuals with respect to my care by report, letter, phone, fax, email or direct communication:

- Physician(s)
- Insurer
- Employer
- Other

_____
INITIALS

Credit Card Holder Authorization

I, the previously-named authorized credit card user, give Evolve Chiropractic and Wellness Center express authorization to charge my credit card for the purposes of 1) Payment for services rendered by any practitioner at Evolve Chiropractic and Wellness Center. 2) Payment for goods purchased from any practitioner at Evolve Chiropractic and Wellness Center. 3) Payment for any outstanding balance I may incur. I understand that this form constitutes a legally binding contract and that by affixing my signature to this form, I will be held responsible for all agreed upon (as stated above) charges as well as any and all collection and legal fees. This credit card is authorized for only the charges noted above.

_____
INITIALS

IF I AM UNABLE TO ATTEND A SCHEDULED APPOINTMENT I WILL PROVIDE 24 HOURS NOTICE TO AVOID BEING CHARGED A MISSED APPOINTMENT FEE OF 100%. I AGREE TO PAY MY FULL ACCOUNT AT THE TIME OF EACH VISIT OR TREATMENT, INCLUDING FEES FOR SERVICE AND ANY GOODS PURCHASED.

I hereby acknowledge that I have discussed with the physiotherapist the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to physiotherapy treatment as proposed to me.

_____ _____
Name (Please Print) Date

_____
Patient Signature (or Legal Guardian)