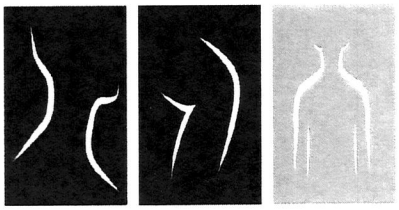
Aline Fournier D.O



Date:_____

Name:_____DOB:_____

Address:_____City:_____State:_____Zip:_____

Email:_____Home/Cell:_____

Employer:_____Work:_____

Emergency Contact:_____Relation:_____Phone:_____

How did you hear about us?_____

Medications

Please list any/add medications or supplements you are currently taking:_____

_____

Are you currently taking any medications for high blood pressure? ____Yes ____No If yes, what is the name of the blood pressure medication you are taking:_____

Are you taking aspirin or any type of blood thinner?_____

____Retin-A ____Differin ____Hydroquinone ____Renova ____Accutane (in the last 6 months)

Other Skin Care Medications/Topical Agents:_____

Allergies

Please list and/all medication allergies:_____

Are you allergic to Latex? ____Yes ____No

Are you allergic to Iodine____Yes____No

Condition

Are you pregnant or plan on becoming pregnant?____Yes____No Are you currently breastfeeding? ____Yes ____No

Do you wear contact lenses? ____Yes ____No Do you have metal implants? ____Yes ____No

Please check all that apply:

____Alcoholism ____Anemia ____Anorexia ____Asthma ____Autoimmune Disease ____Fibromyalgia ____Hepatitis

____Herpes/Cold Sores ____HIV/Aids ____History of Keyloid Scarring ____Bleeding Disorder ____Breast Lump

____Cancer ____Connective Tissue Disorder ____Chemical Dependency ____Migraines ____Multiple Sclerosis

____Neuromuscular Disease ____Pacemaker/Defibrilltor ____Ploycystic Ovaries ____Chronic Fatigue ____Diabetes

____Eating Disorders ____Epilepsy ____Pigmentation Disorder ____Seizures ____Skin Lesion

Skin Care

What is your daily skin regimen?_____

_____

Sun History and Lifestyle

How often are you outdoors? ____Frequently ____Occasionally ____Very Rarely

Is there a family history of skin cancer? ____Yes ____No If so, who? _____

How often do you use sunscreen? ____Frequently ____Occasionally ____Very rarely

How often do you use tanning beds? ____Frequently ____Occasionally ____Very Rarely

Which of the following best describes your skin type?

____Very oily, large pores ____Dry Skin ____Sensitive Skin ____Oily Skin

____Combination skin, oily T-Zone with dry to normal cheeks

Concerns/Interests

____Hair Removal ____Acne ____Rosacea ____Dryness ____Fine Lines ____Wrinkles ____Pore Size

____Discoloration ____Loss of Skin Tone ____Pigmentation ____Brown Spots ____Broken Capillaries/Veins

Other_____

Previous Procedures

Which of the following have you had in the past?

____Botox ____Juvederm ____Radiesse ____Restalyne ____Other Injectables:_____

____Microdermabrasion ____Chemical Peels ____Electrolysis ____Waxing ____Laser Hair Removal

Client Signature:_____Date:_____

Review by:_____Date:_____

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MICRODERMAL NEEDLING

Patient **Consent Form**

Description of the Treatment

The MDPen™ skin needling system allows for controlled induction of the skin's self-repair mechanism by creating micro injuries in the skin to trigger new collagen synthesis, while not posing the risk of permanent scarring. The result is smoother, firmer, and younger-looking skin. Skin needling treatments are performed in a safe and precise manner with the sterile MDPen™ needlehead and are normally completed within 30-60 minutes, depending on the selected area.

Side Effects

After the procedure, the skin may be red and flushed in appearance, similar to moderate sunburn. In the treatment area, skin tightness and mild sensitivity may also be experienced. These side effects will diminish within a few hours following treatment and over the next 24 hours. After 3 days, there will be little evidence that the procedure has taken place.

Contraindications

Contraindications and precautions include: keloid or raised scarring; history of eczema, psoriasis, actinic (solar) keratosis, herpes simplex infections, diabetes, and other chronic conditions; presence of raised moles, warts, or any raised lesions in the target area. Absolute contraindications include: scleroderma, collagen vascular diseases, or cardiac abnormalities; rosacea or blood clotting problems; active bacterial or fungal infections; immuno-suppression; scars less than 6 months old; and facial rollers used in the past 2 - 4 weeks. Treatment is not recommended for patients who are pregnant or nursing.

Patient Consent

I understand that results will vary among individuals. I understand that although I may see a change after my first treatment, I may require a series of sessions to obtain my desired outcome.

The procedure and side effects have been explained to me, including alternative methods. I understand the advantages and disadvantages of this procedure.

I am aware that although good results are expected, the possibility and nature of complications cannot be accurately advised; therefore, there can be no guarantee, expressed or implied, either to the success or other result of the treatment. I am aware that the MDPen™ treatment is not permanent and natural degradation will occur over time.

I agree that I have read (or that it has been read to me) and understand this consent form, and that I understand the information contained in it.

I have had the opportunity to ask any questions about the treatment, including risks and alternatives, and I acknowledge that all my questions about the procedure have been answered to my satisfaction.

THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME, THE BELOW SIGNED PATIENT, IN WRITING:

Print Name: _____ Sign Name: _____

Date: _____ Clinic Name: _____

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MICRODERMAL NEEDLING

Home Care **Instructions**

Day **1**

Red appearance of the skin will vary depending on your treatment and the depth of the penetration of the needles.

Day **2**

Redness or pinkness of the skin will be similar to moderate sunburn. Swelling may be more noticeable.

Day **3**

Skin may still be pink or have returned to normal color. Swelling will subside.

Precautions

- Wash your face thoroughly a few hours after the treatment. Gently massage your face with tepid water so as to remove all serum and other debris, such as dried blood. Do not use a chemical sunscreen on the same day as your treatment.
- For the first 1-3 days, your skin will be very dry and may feel tight. Frequent use of an HA (hyaluronic acid) serum or other moisturizer will help alleviate this condition.
- After 2-3 days, or as soon as it is comfortable for you to do so, you can return to using your regular skin care products. Products containing Vitamin A are recommended.
- Avoid alcohol-based toners for 10-14 days.
- Avoid direct sun exposure for 3-5 days, if possible. Use sun protection as suggested by your practitioner.

Home skin care checklist:

- ✔ **CLEANSE –** Use a soothing cleanser or facial wash with tepid water to cleanse your face for the following 48 hours. Dry gently. Always make sure your hands are clean when touching the treated area.
- ✔ **SOOTHE –** Copper-based skincare is recommended, post-treatment, as the mineral properties are perfect to help heal your skin and will sterilize it as well. Resveratrol-based products can help soothe the skin and lessen irritation.
- ✔ **HYDRATE –** Following your treatment, the skin may feel drier than normal. Hyaluronic acid is an ideal ingredient to hydrate and restore your skin back to a perfect balance.
- ✔ **MAKE-UP –** It is recommended that make-up is not applied for 12 hours after the procedure. Do not apply any make-up with a make-up brush or other applicators that might not be sterile.
- ✔ **PROTECT –** Apply a practitioner-approved sunscreen, if needed. Take precautions against exposure to the sun. Have no direct exposure to the sun for 3-5 days post-treatment. Do not apply chemical sunscreen for 24 hours post-treatment.

Print Name: _____ Sign Name: _____

Date: _____ Clinic Name: _____

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CONSENT TO MEDICAL TREATMENT: Mesotherapy

NOTE TO THE PATIENT: There are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand to the planned treatment.

I authorize Dr. Fournier to perform the treatment commonly known as Mesotherapy which is the injection of a homeopathic solution into the dermis (mesoderm). _____

RISKS: I understand the possible risk of redness, bruising, swelling, itching and tenderness at the injections site, dizziness, hypertension, epidural infiltration, headache, nausea that typically resolve within a few days. Localized granulomatous, abscesses, bacterial infection, papulocystic nodules, acne and cytic lessions, anesthesia, allergic reaction to a component of some injection solutions have occured rarely, _____

ALTERNATIVE METHODS OF TREATMENT: I am satisfied with my understanding of alternative procedures of treatment and their possible benefits and risks which include surgery with local anesthesia, sugery with general anesthesia, injection with collegen or other substances, or to do nothing. _____

NO TREATMENT: I am satisfied with my understanding of the possible consequences, outcome, and risks if no treatment is rendered.

SECOND OPINION: I have been offered the opportunity to seek a second opinion concerning this proposed treatment.

I understand it is not possible to guarantee an immediate successful result, and all of my questions about this treatment have been answered satisfactorily.

Date: _____

Signature: _____

patient, parent, or legal guardian

Aline G. Fournier, DO
307 So Ivy Street
Escondido, CA. 92025

COVID-19 Emergency Treatment Consent Form

I, _____(patient), consent to receive emergency treatment from Aline Fournier, DO during the Covid-19 outbreak.

I understand there is much to learn about the newly emerged Covid-19 including how is spreads and is transmitted.

I understand that based on what is currently known about Covid-19 the spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts. I understand that close contact can occur from being approximately 6 feet of someone with Covid-19 or by having direct contact with infectious secretions from someone with Covid-19.

I understand that carriers of Covid-19 may not show symptoms but may still be highly contagious.

I understand that due to the unknowns of this virus, the number of other patients that have been in the practice and the nature of procedures performed here, that I have an increased risk of contracting the virus by being in the practice and by receiving treatment in the practice.

I understand that CDC guidelines do not recommend proceeding with any treatment that is non-essential at this time.

I understand that the treatment I am receiving is an emergency because of the underlying infection, pain or conditions that limit my normal day-to-day activities. I confirm I am seeking treatment for a condition that meets these criteria. _____

I understand that the symptoms listed are representative of Covid-19:
Fever, Dry Cough, Shortness of Breath, Persistent pain or pressure in the chest, Bluish lips or face.

I confirm that I do not display or currently have any of the symptoms that are representative of Covid-19, which are listed above. _____

I understand that all travelers from a country or region with widespread ongoing transmission, as outlined by the CDC, should stay home for 14 days to practice social distancing and monitor their health after their arrival.

I confirm that I have not traveled to any of the countries or regions with widespread, ongoing transmission (Level 3 Travel Health Notice) in the past 14 days. _____

I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with Covid-19 in the past 14 days. _____

Patient Name: _____

Signature: _____

Date: _____

Doctor Signature: 

Date: _____

Omnilux blue light therapy

Precautions due to drug induced photosensitivity for Blue light treatment

Optimum results will be seen between 4-12 weeks after the course of treatments is complete, with a majority of people seeing their best response 8 weeks after the treatment conclusion. Some of our study subjects have experienced increased acne lesions during their treatment, due to the detoxification process of the treatment, however this settles down once the treatment is complete. The light stimulates natural processes that continue after the treatment has stopped.

You will have to remove any make-up or sun block before the treatment and cease to use any topical retinoids. You will be asked to wear some eye safety goggles which MUST be worn.

It is not advisable to have sun bed treatments in conjunction with your course of Blue light therapy. You can continue with your antibiotic treatment if it is not excluded on our treatment contra-indication list.

Please indicate if you are taking or have taken any of the following medication:

Drug: Codarone X or Aratac **Use: Anti-Arrhythmic**

Yes ☐ If yes, it is at your discretion whether you commence with the treatment.

No ☐ If no, enjoy Omnilux blue!

Drug: Ridaura or Gold 50 **Use: Anti-Arthritis**

Yes ☐ If yes, the treatment cannot be administered.

No ☐ If no, enjoy Omnilux blue!

Drug: Azathioprine **Use: Anti-Arthritis**

Yes ☐ If yes, the treatment can be administered as long as the medication has not been taken within the last 5 days.

No ☐ If no, enjoy Omnilux blue!

Drug: Grisovin **Use: Anti-Fungal Antibiotic**

Yes ☐ If yes, the treatment can be administered as long as the medication has not been taken within the last 5 days.

No ☐ If no, enjoy Omnilux blue!

Drug: Tetracycline group **Use: Antibiotic**

including Minomycin, Tetracycline, Oxytetracycline, Lymecycline, Demeclocycline, Vibramycin

Yes ☐ If yes, the treatment can be administered as long as the medication has not been taken within the last 5 days.

No ☐ If no, enjoy Omnilux blue!

Drug: Roaccutane **Use: Anti-Acne**

Yes ☐ If yes, the treatment can be administered as long as the medication has not been taken within the last 5 days.

No ☐ If no, enjoy Omnilux blue!

Drug: Ledertrexate/Methotrexate **Use: Anti-Cancer**

Yes ☐ If yes, the treatment can be administered as long as the medication has not been taken within the last 3 days.

No ☐ If no, enjoy Omnilux blue!

Drug: Quinolone group **Use: Antibiotic**

including Nalidixic acid, Norfloxacin, Ciprofloxacin, Ofloxacin

Yes ☐ If yes, the treatment can be administered as long as the medication has not been taken within the last 5 days.

No ☐ If no, enjoy Omnilux blue!

Drug: Chlorpromazine **Use: Anti-Arrhythmic**

Yes ☐ If yes, the treatment can be administered as long as the medication has not been taken within the last 5 days.

No ☐ If no, enjoy Omnilux blue!

Client Consent for Omnilux treatments

I have read and understood the information provided and I am fully aware of the nature of the treatment, why and how it is to be performed and any possible side effects. I have been given the opportunity to ask questions.

My signature below indicates my informed decision to have the treatment.

Warning: If during your course of treatments you develop persistent headaches or some puffiness/itching or prolonged redness of the skin, you may be showing signs of light sensitivity. In this case, please notify your treatment consultant immediately and discontinue your treatment.

Signature: _____

Print Name: _____ D.O.B: _____

Address: _____

_____

_____

Postcode: _____

Date: _____

Telephone number: _____

Witnessed by treatment consultant: _____

Signature: _____

Print Name: _____

Salon name: _____

Date: _____

Position: _____

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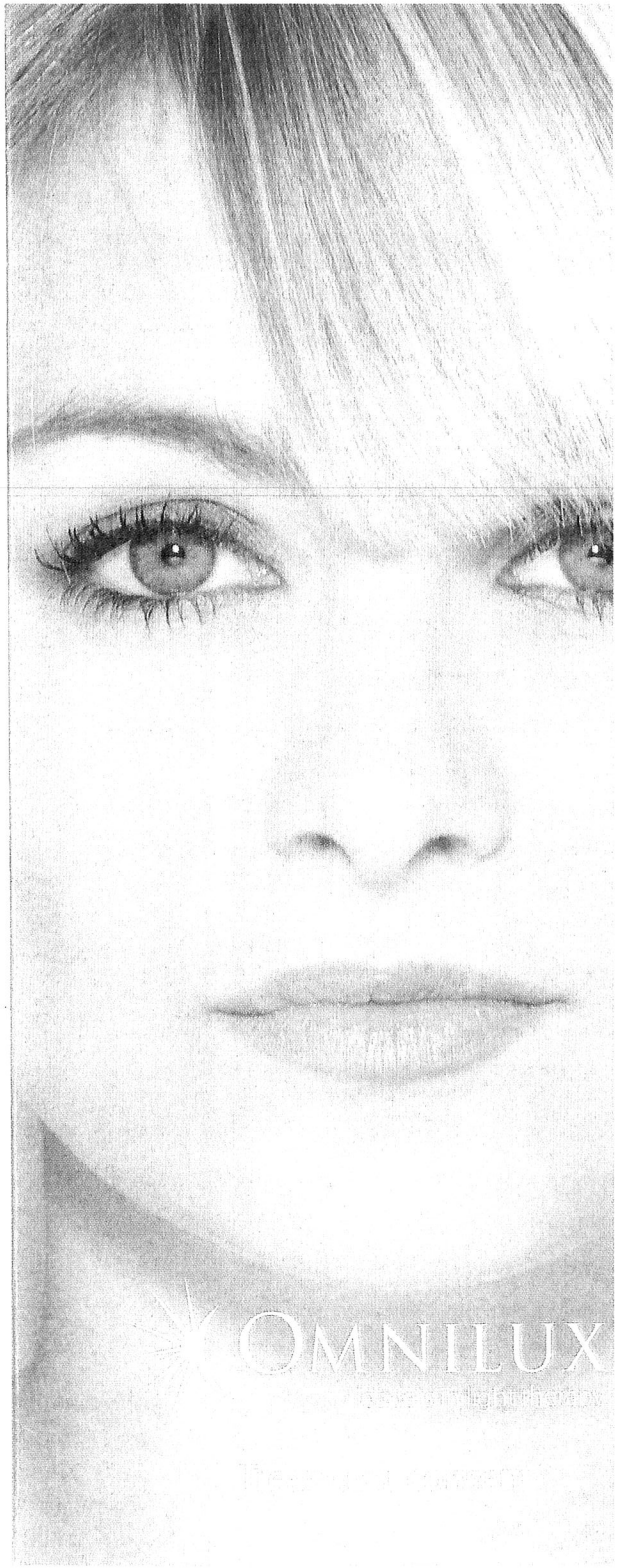

Before commencing an Omnilux treatment you must complete this form. These forms are designed to help assess your skin type and to explain the short and long-term benefits and effects of Omnilux.

Pre-treatment consultation

Client skin type (1-6):

SKIN TYPE	COMPLEXION TYPE
Type 1	Very pale, always burns, never tans
Type 2	Fair skin and hair, burns easily, tans minimally
Type 3	Slightly darker skin, burns sometimes, tans gradually
Type 4	Mediterranean; burns rarely, tans easily
Type 5	Asian/Arabic; burns rarely, always tans
Type 6	Afro-Caribbean; never burns, always tans

Which skincare products do you use for the:

Eyes

Face and Neck

Do you regularly use a cream with an SPF? Yes ☐ No ☐

If yes, please specify which cream for which area and the SPF factor:

Eyes

Face and Neck

Have you had any of the following treatments in the last 24 hours?

Microdermabrasion ☐ Oxygen facials e.g. Oxyjet ☐

Microcurrent facial ☐ Facial Peels ☐

e.g. Caci, Biotherapeutic etc. Injectables ☐

48 hours should be left between the above treatments and Omnilux.

Precautions and Contra-indications for Omnilux treatments

There are a number of conditions/instances in which light therapy may prove to be unsuitable for an individual i.e. if you are taking certain forms of medication or you suffer from a photosensitive disorder. Photosensitivity means a reaction to normal amounts of sunlight.

Are you Pregnant? Yes ☐ No ☐

Do you suffer from Epilepsy? Yes ☐ No ☐

Do you suffer from Porphyria? Yes ☐ No ☐

Do you suffer from Lupus Erythematosus? Yes ☐ No ☐

If you have answered yes to any of these questions, you are not suitable for Omnilux.

Do you take St. Johns Wort? Yes ☐ No ☐

If yes, you may be more light sensitive. It is at your discretion whether you commence with the treatment.

Omnilux revive light therapy

Precautions due to drug induced photosensitivity for Red light treatment

The effectiveness of light therapy will vary between individuals. All our 'study subjects' have experienced signs of skin rejuvenation. Some subjects have also experienced noticeable smoothing of their fine lines and wrinkles. Although the light from Omnilux is safe, it is very bright. For your comfort during treatment we recommend you wear the eye protectors provided.

Please indicate if you are taking or have taken any of the following medication:

Drug: Codarone X or Aratac **Use: Anti-Arrhythmic**

Yes ☐ If yes, it is at your discretion whether you commence with the treatment.

No ☐ If no, enjoy Omnilux revive!

Drug: Ridaura or Gold 50 **Use: Anti-Arthritis**

Yes ☐ If yes, the treatment cannot be administered.

No ☐ If no, enjoy Omnilux revive!

Drug: Azathioprine **Use: Anti-Arthritis**

Yes ☐ If yes, the treatment can be administered as long as the medication has not been taken within the last 5 days.

No ☐ If no, enjoy Omnilux revive!

Drug: Grisovin **Use: Anti-Fungal Antibiotic**

Yes ☐ If yes, the treatment can be administered as long as the medication has not been taken within the last 5 days.

No ☐ If no, enjoy Omnilux revive!

Drug: Tetracycline group **Use: Antibiotic**

including Minomycin, Tetracycline, Oxytetracycline, Lymecycline, Demeclocycline, Vibramycin

Yes ☐ If yes, the treatment can be administered as long as the medication has not been taken within the last 5 days.

No ☐ If no, enjoy Omnilux revive!

Drug: Roaccutane **Use: Anti-Acne**

Yes ☐ If yes, the treatment can be administered as long as the medication has not been taken within the last 5 days.

No ☐ If no, enjoy Omnilux revive!

Drug: Ledertrexate/Methotrexate **Use: Anti-Cancer**

Yes ☐ If yes, the treatment can be administered as long as the medication has not been taken within the last 3 days.

No ☐ If no, enjoy Omnilux revive!

Drug: Quinolone group **Use: Antibiotic**

including Nalidixic acid, Norfloxacin, Ciprofloxacin, Ofloxacin

Yes ☐ If yes, the treatment can be administered as long as the medication has not been taken within the last 5 days.

No ☐ If no, enjoy Omnilux revive!

Drug: Chlorpromazine **Use: Anti-Arrhythmic**

Yes ☐ If yes, the treatment can be administered as long as the medication has not been taken within the last 5 days.

No ☐ If no, enjoy Omnilux revive!

Omnilux plus light therapy

Precautions due to drug induced photosensitivity for Omnilux plus treatment

You will have to remove any make-up or sun block before the treatment.

You will be asked to wear eye safety goggles which MUST be worn.

Please indicate if you are taking or have taken any of the following medication:

Drug: Codarone X or Aratac **Use: Anti-Arrhythmic**

Yes ☐ If yes, it is at your discretion whether you commence with the treatment.

No ☐ If no, enjoy Omnilux plus!

Drug: Ridaura or Gold 50 **Use: Anti-Arthritis**

Yes ☐ If yes, the treatment cannot be administered.

No ☐ If no, enjoy Omnilux plus!

Drug: Azathioprine **Use: Anti-Arthritis**

Yes ☐ If yes, the treatment can be administered as long as the medication has not been taken within the last 5 days.

No ☐ If no, enjoy Omnilux plus!

Drug: Grisovin **Use: Anti-Fungal Antibiotic**

Yes ☐ If yes, the treatment can be administered as long as the medication has not been taken within the last 5 days.

No ☐ If no, enjoy Omnilux plus!

Drug: Tetracycline group **Use: Antibiotic**

including Minomycin, Tetracycline, Oxytetracycline, Lymecycline, Demeclocycline, Vibramycin

Yes ☐ If yes, the treatment can be administered as long as the medication has not been taken within the last 5 days.

No ☐ If no, enjoy Omnilux plus!

Drug: Roaccutane **Use: Anti-Acne**

Yes ☐ If yes, the treatment can be administered as long as the medication has not been taken within the last 5 days.

No ☐ If no, enjoy Omnilux plus!

Drug: Ledertrexate/Methotrexate **Use: Anti-Cancer**

Yes ☐ If yes, the treatment can be administered as long as the medication has not been taken within the last 3 days.

No ☐ If no, enjoy Omnilux plus!

Drug: Quinolone group **Use: Antibiotic**

including Nalidixic acid, Norfloxacin, Ciprofloxacin, Ofloxacin

Yes ☐ If yes, the treatment can be administered as long as the medication has not been taken within the last 5 days.

No ☐ If no, enjoy Omnilux plus!

Drug: Chlorpromazine **Use: Anti-Arrhythmic**

Yes ☐ If yes, the treatment can be administered as long as the medication has not been taken within the last 5 days.

No ☐ If no, enjoy Omnilux plus!