



BLOSSOM
MEDICAL

LYNN NIEMAN, MD

1820 West Plaza Drive
Winchester, VA 22601
540.323.7254

Please Fill Out the Following Information:

Name: _____

Address: _____

Home Phone: _____

Cell Phone: _____

e-mail address: _____

Birth Date: ____/____/____

Emergency Contact (name/number): _____

If I need to reach you, what is your preference? (circle one)

Phone Call

Text Message

How did you hear about Blossom Medical? _____

Thank You,

Dr. Lynn Nieman



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Medical History:

Name:

DOB:

Do you have any of the following Medical Conditions?:

- | | | |
|--------------------------|--------------------|------------------------------|
| • Stroke | Thyroid Disease | Asprin Intolerance |
| • Carotid Stenosis | Diabetes | Heart Disease |
| • Lyme's Disease | PCOS | Hypertension |
| • Bell's Palsy | Breast Cancer | Arrhythmia |
| • Neuromuscular Disorder | Menopause | Valve Replacement |
| • Muscular Dystrophy | Seasonal Allergies | Pacemaker |
| • Myasthenia Gravis | Asthma | Other (please specify below) |

Please list the medicines you take on a regular basis: _____

Have you had any surgeries? (Please list): _____

Have you had a previous cosmetic procedures (i.e. botox, fillers, laser treatments)? (please list): _____

Have you had any adverse reactions during a procedure? (ie nodule formation, unhappy with result): _____

Allergies to Medications? _____

Allergies to fruit, milk, or other food: _____

Are you under the care of a dermatologist? _____

Who is your PCP? _____

Thank You,

Dr. Lynn Nieman



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HIPPA Consent:

I give Blossom Medical Aesthetics, PC my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care options like quality reviews.

I give Blossom Medical Aesthetics, PC my consent to use or disclose my protected health information in order to obtain payment for services and/or product. I have been informed that I may review Blossom Medical Aesthetics, PC Notice Of Privacy Practices (for a more complete description on uses and disclosures) before signing this consent. I understand that Blossom Medical Aesthetics, PC has the right to change their privacy practices and that I may obtain any revised notices at the clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Blossom Medical Aesthetics, PC is not required to agree to the request. If Blossom Medical Aesthetics, PC agrees to my requested restriction, they must follow the restriction(s). I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed. Patient, parent or legal guardian:

Signature: _____

Date: _____

Thank You,

Dr. Lynn Nieman



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Photography Consent:

Name: _____

I understand that Blossom Medical may take photographs as part of my medical treatment. I understand that photographs are private and protected under HIPPA.

Occasionally, Dr. Nieman or Blossom Medical may request permission to use a treatment before and after photographs for such purposes to demonstrate the type of aesthetic work done by Blossom Medical.

These photographs are only shown with the express permission of the patient.

Permission to share photographs (please check):

_____ I Do give my permission for my photographs to be shared

_____ I DO NOT give permission for my photographs to be shared

Thank You,

Dr. Lynn Nieman

BOTOX CONSENT



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This form is not just a formality- it's a record of your decision to consent to a procedure having considered the risk of both positive and negative outcomes and medical risks listed below, and the impact they may have on your well-being. Please sign to indicate you have read, understood and discussed as required with your clinician.

What is being injected? Botox/Dysport These products causes muscle relaxation and suppress sweating for 2- 6 months on average (with wide variation between individuals) by temporarily disrupting nerve activity to muscles and sweat glands.

What are the side Effects and Risks?

- Transient headache, swelling, bruising, bleeding, pain, itching, numbness or change of sensation around eyes,
- Allergy including anaphylaxis is possible but very rare.
- Asymmetry (unevenness)
- Temporary drooping of facial features, including eyebrows, cheeks, and mouth.
- Dry eyes
- Double or blurred vision
- The theoretical risk of complications unique to certain individuals or so far unknown.

Interactions: I have disclosed my medical and drug history to my clinician and am aware that many medications increase the risk of bruising and include but are not limited to Vitamin E, aspirin, Motrin, clopidogrel, warfarin and others.

Limitations and alternatives: Botulinum Toxin is best at treating dynamic facial lines; those caused by facial muscle activity, lines present at rest may or may not improve and can be unpredictable. I have considered alternatives to treatment, including doing nothing, topical creams, chemical peels, laser treatments, surgical denervation, forehead/brow lift, facelift, or hyaluronic acid treatments and elected that at this time Botulinum toxin is the best option for me.

Follow-up: I understand that I may need a touch-up and that Dr. Nieman will perform that between 14-21 days after injection.

Dissatisfaction: I understand that with all treatments the actual degree of improvement cannot be predicted or guaranteed. The outcome's Agreement: outcome and decided the treatment is still in your best interests at this moment in your life. You have discussed all the details of the treatment plan, past treatments and your medical history with your clinician and shared all the information your clinician may need to plan a treatment. You agree that this included in the cost of the procedure and therefore no refunds are issued due to any of the above occurring. I understand photographs are taken and stored for 7 years as part of my clinical record:

Client: Name:Signature:.....Date:

.....



DERMAL FILLER CONSENT

LYNN NIEMAN, MD

1820 West Plaza Drive
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What is being injected? Hyaluronic acid injectables include branded products such as Juvederm, Restylane, Boletero, Profillio and others improve the appearance of lines, correct volume loss or alter proportions. They include in their makeup mainly water, hyaluronic acid, lidocaine anaesthetic, and stabilising molecules such as BDDE (1,4-Butanediol Diglycidyl Ether).

Risks of injection: Trauma during the procedure is caused by needles and cannulas passing through tissue, and includes bleeding, bruising, haematoma (a larger collection of blood in the skin, outside of blood vessels), damage to underlying structures including veins, arteries, nerves, salivary glands, lymph nodes, bone, muscle and other soft tissue structures are possible. In rare cases this could cause continuous problems in appearance, sensation or function and may require medical intervention to treat or may be permanent. Most traumatic injuries heal completely on their own.

Infection: Bacterial, viral or fungal infections can occur post procedure. Infections can cause redness and swelling and resolve or progress into abscesses or biofilms which can be slower to recover. Rarely infections occur months later as 'biofilm reactions'. Symptoms include itching, and a lumpy or "thick" feeling at or just under the skin. Injections into the lip area could trigger a recurrence of cold sores (Herpes simplex infections) which may require treatment. These problems may resolve in time, but medical intervention may be required in some cases, and long-term effects may persist in rare cases.

Reactions: Reactions rarely occur but can include an immediate reaction causing swelling, and very rarely life threatening anaphylaxis. Delayed reactions localised to the skin can cause nodules, lumps or bumps or very rarely sterile abscesses. These may occur soon after the procedure or months later. They may require treatment and may leave permanent effects on the appearance, sensation and function of the areas affected. The chance of a reaction is reported to be 0.5% or 1 in 200. The chance of delayed reaction increases if you have active autoimmune disease or an active immune system including viral or bacterial infections elsewhere.

Lumps, Bumps, Swellings- Unwanted visual side effects may cause dissatisfaction or distress, and include an increase in asymmetry, swelling, lumps, bumps puffiness or surface irregularities. These non-inflamed filler side effects are temporary and treatable with full resolution likely.

Skin Changes-Procedures are rarely associated with pigment changes, the formation of thread veins or new capillaries, and other blemishes. These may either recover, require further treatment or be permanent.

Blood Vessel Blockage: In rare instances the blood supply can be blocked by filler. This can cause local tissue injury called 'necrosis', which can result in permanent scarring. There are extremely rare cases in which blood supply to the eye or parts of the brain being affected causing blindness and stroke. Seeking help immediately if you suspect blood vessel occlusion is vital to prevent scarring.

Initial_____



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DERMAL FILLER CONSENT

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Follow-up: I understand adjustments requiring more product incur a charge.

Dissatisfaction: I understand that with all treatments the precise degree of improvement cannot be guaranteed. The outcome's subjective nature also means dissatisfaction is a possible outcome regardless of effectiveness of treatment. I understand that the effect of all treatments may gradually wear off, additional treatments may be necessary to acquire the desired effect, and further charges will apply if more product is required.

Agreement: By signing this form, you agree that you have read this form carefully and considered the side effects, risks and uncertainty of the outcome and decided the treatment is still in your best interests. You have discussed all the details of the treatment plan, past treatments and your medical history with your clinician and shared all the information your clinician may need to plan a treatment. You agree that the balance of the benefits and risks to you overall favour the use dermal filler. You understand that the initial treatment of side effects and complications is included in the cost of the procedure and therefore no refunds are issued due to any of the above occurring. You understand photographs are taken and stored for 7 years as part of my clinical record:

Client: Name:Signature:.....Date:

DERMAL FILLER INSTRUCTIONS



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What's Normal after a Procedure?

Due to the anaesthetic in the gel, you may feel numbness or tingling immediately after the procedure, and have some moderate swelling, redness, bruising and tenderness over areas treated. Some people experience a dull ache, and tenderness over the treated areas which subsides between 48-72 hours. Mild, non-painful swelling can last for up to 2 weeks. Bruising is usually visible initially, then more obvious the next day before fading over 7 to 14 days. A small minority of bruises can last for 4-6 weeks.

How to Protect Your Result & Reduce Side Effects

- For 48 hours you should avoid exposure to UV light and heat i.e. sauna, steam, sun beds, hot showers, strenuous exercise etc, as this may increase discomfort and swelling.
- Keep the area cool with a cold compress, but don't apply ice which can cause injury.
- Try to avoid unnecessary pressure over any areas treated, especially in the first 24 Hours.
- Avoid facial massages or skin resurfacing until the area has healed fully.

Reduce the Chance of Infection:

Reduce the risk of infection and reaction by not touching the area for 6 hours. Do not apply make-up over injection points until the day after the procedure.

When to Contact Us...

Serious complications are rare, but it's vital you seek urgent review if anything like this occurs:

- Swelling, puffiness or lumpiness which does not fade in the first week with a gentle massage.
- The filler changes texture and becomes hard, nodular or lumpy, especially if there is redness or tenderness after 48 hours. All these symptoms may indicate a need for medical assistance from your clinician or family doctor if you are unable to see us, but please contact us so we can advise.

IMPORTANT: Contact us immediately if you have symptoms of a blocked blood vessel. If you develop increasing pain near or above the site of injection which is getting worse over time, especially if associated with a pale area of skin indicating a lack of blood flow you should contact us straight away. In rare cases, an urgent reversal or other medical interventions may be required immediately to prevent scarring. If we are unreachable attendance at accident and emergency is advised. Make contact with us soon as possible so we can advise other clinicians to help them.
(after hours you can text me at 919.609.9012 for an emergency)



BOTOX INSTRUCTIONS

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Today you may have undergone a treatment in which a tiny amount of a muscle relaxing protein has been injected into muscles to improve appearance. It will usually take between 3 and 10 days to start to see any muscle relaxing effect and 14 days until the full effect has been reached.

What is normal after the procedure?

Injections can cause small amounts of swelling, a temporary bump, redness, bruising, a mild to moderate headache, and sensations such as tingling or mild itching after the treatments. These effects are so common they can be considered a normal part of the process. The initial effects will show in the first 2-5 days. Peak effect on the muscle is at 14 days, but the result will continue to improve for 4 weeks or more. The benefits start to wear off after 3-4 months on average.

How to Protect Your Result & Reduce Side Effects-

- Remain upright for 2 hours.
- Do small extra contractions of the muscles treated every 20 minutes for the first hour.
- When cleansing, avoid pressure and use gentle strokes away from the eyes.
- Avoid facial massages or electrical stimulation of the face for the next 2 weeks.
- Avoid wearing tight caps or garments in the area that has been injected.
- Avoid alcohol and exposure to UV and extreme heat i.e. sauna, steam, sun beds, very hot showers, strenuous exercise etc

Reduce the Chance of Infection:

- Do not apply make-up for approximately 6 hours unless it is mineral based.
- Wash your hands immediately post procedure
- Do not touch your face in the areas injected for 6 hours.

Contact us...-

If you develop a side effect, such as a dry eye, droopy eyelid, heavy brow.

- Any other side effects you think are important.
- If you feel distressed or worried in any way.
- Routine adjustments can be carried out from day 14 (ideally close to day 14, no longer than 21 days) after your procedure.



HYALURONIDASE CONSENT

LYNN NIEMAN, MD

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This form is not just a formality- it's a record of your decision to consent to a procedure having considered the risk of both positive and negative outcomes and medical risks listed below, and the impact they may have on your well-being.

What is being injected?

Hyaluronidase is an enzyme that breaks down dermal fillers made of hyaluronic acid into small sugars which easily disperse.

Risks of the procedure include but may not be limited to:

Risks of injection:

Trauma during the procedure is caused by needles and cannulas passing through tissue, and includes bleeding, bruising, haematoma (a larger collection of blood in the skin, outside of blood vessels), damage to underlying structures including veins, arteries, nerves, salivary glands, lymph nodes, bone, muscle and other soft tissue structures are possible. In rare cases this could cause continuous problems in appearance, sensation or function and may require medical intervention to treat or may be permanent. Most traumatic injuries heal completely on their own

Reactions:

Allergic reaction including anaphylactic shock are possible, they occur at a rate of between 1/2000 and 1/100 depending on the data source. Anaphylactic shock has a mortality rate 0.3 to 5% depending on the study. An allergy test can often identify this risk prior to full exposure. Local reactions include oedema, erythema, pain and itching, urticaria and angioedema.

Side Effects:

Hyaluronidase dissolves hyaluronic acid including molecules made by your body and previous treatments that you may wish to preserve could also be dissolved. You therefore could notice a reduction in skin elasticity and volume and associated asymmetry which typically would last a few days. It is common to cause bleeding, bruising, some swelling or oedema and redness near the injection site.

Treatment Failure: It is possible that the procedure will fail to remedy the problem as often HA is not the sole cause of lumps, bumps or reactions, which may be caused by other materials.

Complications from infection: There is a small risk of introducing an infection, and a theoretical risk that pre-existing infection could spread further if hyaluronidase is injected into the area, risking septicaemia though there are no recorded cases.

I confirm I do not have any known allergies to hyaluronidase, and to your knowledge you do not have any active cancers in the area injected and you are not pregnant or breastfeeding.

Follow-up: I understand adjustments requiring more product incur a charge.

Dissatisfaction: I understand that with all treatments the precise degree of improvement cannot be guaranteed. The outcome's subjective nature also means that dissatisfaction is also possible regardless of an effective treatment. I understand that the effects of the treatment may gradually wear off, additional treatments may be necessary to acquire the desired effect, and further charges may apply.



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HYALURONIDASE CONSENT

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Agreement:

By signing this form, you agree that you have read this form carefully and considered the side effects, risks and uncertainty of the outcome and decided the treatment is still in your best interests. You have discussed all the details of the treatment plan, past treatments and your medical history with your clinician and shared all the information your clinician may need to plan a treatment. You agree that the balance of the benefits and risks to you overall favor the use of hyaluronidase. You understand that the initial treatment of side effects and complications is included in the cost of the procedure and therefore no refunds are issued due to any of the above occurring. You understand photographs are taken and stored for 7 years as part of my clinical record:

Client: Name:Signature:.....Date:

COVID19 CONSENT



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Winchester, VA 22601
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INFORMED CONSENT - COVID-19 PANDEMIC

I _____, understand that I am opting for an elective treatment/procedure/surgery that is not urgent and may not be medically necessary. I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact and accordingly, federal and state health agencies recommend social distancing.

I recognize that the medical providers and staff at **Blossom Medical** are closely monitoring this situation and have put in place reasonable preventive measures targeted to reduce the spread of COVID-19. Given the nature of the virus, however, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure.

I acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure, and I give my express permission for the medical providers and staff at **Blossom Medical** to proceed with the same.

I understand that even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that if I have a COVID-19 infection and even if I do not have any symptoms, proceeding with this elective treatment/procedure can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure may result in any of the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, intensive care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described in this Informed Consent, as well as those risks for the treatment/procedure itself.

Initials (1/2 pages) _____



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INFORMED CONSENT - COVID-19 PANDEMIC

I have been given the option to defer my treatment/procedure/surgery to a later date. However, I understand all the potential risks, including, but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery. I acknowledge that I have been offered a copy of this consent form. I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.

Printed Patient Name _____

Date _____

Practice Representative Name _____

Signature of Patient/Personal Representative _____

Date _____

Signature of Practice Representative/Witness _____