MEDICAL SPA
Dream Weight + Botox Clinic
MS Location:1060 E County Line Rd, Suite 1A, Ridgeland Mississippi, 39157 769444-5673
ATL Location: 2521 Piedmont Rd NE, Suite 2101, Atlanta Georgia, 30324 706-509-2345
www.dreamweight.me office@dreamweight.me

Please fill out this form and bring it with you on your first appointment with your photo ID

First Name_____ **MI**_____ **Last Name**_____

Date of Birth _____/_____/_____ **Age:** _____

Address: _____

City/State: _____Zip:_____

Phone: _____ **Email:** _____

Emergency Contact and phone_____

Occupation: _____

Primary Physician: _____

Current Medications including prescription for skin care (Accutane)

1.) _____ **2.)** _____

3.) _____ **4.)** _____

5.) _____ **6.)** _____

7.) _____ **8.)** _____

Over the counter meds/supplements
_____
_____

Please list any current or past laser, hair removal or major surgeries with date
_____
_____
_____
_____

Ÿ**Any known drug allergies?**

_____

_____

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I _____ willingly authorize **Dr. Rommel Asagwara, MD** and the staff of Dream Weight Botox Clinic to carry out treatment with their laser, radio frequency, or hair removal machine. I understand that the treatment is tailored to my skin type and needs and the results may differ from person to person.

I agree that I got all the information necessary for me to get started on the treatment plan and that things may change during the course of the treatment allowing the team to adapt the treatment to get me the best possible combination as needed.

I understand that this is a participative and voluntary program from which I may withdraw at any time.

I understand that before and after pictures are a necessary part of the treatment plan and I willingly consent to having my pictures taken for medical purposes and such pictures could be used for teaching or to show other patients of my result if necessary.

I certify that I will disclose all my medical history and medications to Dream Weight Clinic staff and to Dr. Rommel Asagwara while I participate as a patient in their program. I certify that I will not receive other laser or radio frequency or hair removal options at the same time as that as Dream Weight Botox Clinic until I am outside of my treatment timeframe.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Date: _____ Patient: _____
(Or person with authority to consent for patient)

Notice of Privacy

Our Notice of Privacy Practices provides information about how we may use disclose protected health information about you. You have the right to review our Notice of Privacy Practices before signing this acknowledgment. As provided in our Notice, The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by requesting a copy from the Privacy Officer, Dream Weight Clinic, 1060 E County Line Rd, Suite 1A, Ridgeland, MS, 39157 or 2521 Piedmont Rd NE, Suite 2101, Atlanta GA, 30324 or contact us at office@dream-weightclinic.me

By signing this form, you acknowledge that you have been provided a copy of our Notice of Privacy Practices.

Patient Signature _____ Date _____