



Input _____

ASPIRE _____

Emmanouil Karampahtsis NMD
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(480) 664-2288 www.lipogenex.com

DYSPORT/FILLER INTAKE FORM

Name: _____ Date: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: Cell: _____ Home: _____ Work: _____

Date of Birth: _____ Age: _____ Sex: M / F (circle one)

Email address: _____

How did you learn about Lipogenex?

- Already a Client Ad _____ Website Groupon Web Search Walk-In/Sign
- Referred by: _____ Other: _____

In case of emergency, who should we contact:

Name: _____ Phone: _____

List all known allergies (food, drugs, environment, etc): _____

Current Medication / Supplements: _____

How often do you take the following (the following could increase your chances of bruising at an injection site):

Ibuprofen / Aspirin - How often: _____

Fish Oil - How often: _____

Vitamin E - How often: _____

Red Wine - How often: _____

Have you had the following services in the past and how often?

- Restylane (or Juvederm) - How often: _____
- Bellafill - How often: _____
- Other Dermal Filler - How often: _____
- Dysport- How often: _____
- Botox or Xeomin - How often: _____

Areas of Dysport/Botox previously injected and units used:

- Forehead - Units ____
- Between Eyes - Units ____
- Crows Feet - Units ____
- Other ____

Have you ever had a side effect from a dermal filler or neurotoxin? If yes please explain _____

**Have you had the following services in the past
or are you interested in learning more about our other services?**

- Laser Skin Resurfacing
 - Pixel/Fraxel
 - CO2
 - J-PlasmaWhen: _____ Interested in learning more
- Photofacial (IPL for sun damage and brown spots)
When: _____ Interested in learning more
- Bio-Identical Hormone Balancing
When: _____ Interested in learning more
- Laser Skin Tightening/Body Contouring
When: _____ Interested in learning more
- HCG Diet, or other medically supervised weight loss programs
When: _____ Interested in learning more
- Chemical Peels
When: _____ Interested in learning more

PHOTO RELEASE

I, grant Lipogenex the right and permission to use images of me for the following purposes:
(check all that apply)

- Use in my chart only
- To be shown to other clients and potential clients to demonstrate possible results
- Newspaper or online advertising
- All purposes, including marketing purposes in all media

Signature: _____

Date: _____



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Office Policies & Fees
Effective 9-1-17

- Consultation Fees:

One-Hour Initial Consultation:	\$300
One-Hour Follow Up Consultation:	\$175
30-Min Follow Up Consultation:	\$125

- Labs for Hormones are drawn every 6 months for all Hormone Therapy Patients, plus a 30 minute follow up consultation to review any changes or updates. * New Hormone therapy patients will have a follow-up consultation at 3 months in addition to new labs and consult at 6 months.

- Hormone Medication Refills: Call the office 2 weeks prior to your last day of medication.

- No Refund Policy: It is the policy of Lipogenex Anti-Aging Center that no refunds will be issued once an initial purchase has been made. If treatment is declined, the purchaser may receive the full amount in house credit toward alternative treatments. Only the amount paid is redeemable towards house credit taking into account discounts that were taken at the time of original purchase. When treatment packages are used the full cost of each treatment will be deducted from the amount paid and the remaining balance can be redeemed toward house credit if other treatment options are pursued.

- Cancellation Policy: There is a 48-hour cancellation policy. Any cancellations less than 48 hours before a scheduled appointment will be subject to a \$40 cancellation fee.

- Weight-Loss Policy: To keep our costs low, we are unable to provide any exchange or refunds of all diet programs or products.

- Injectables: A product is considered compromised and no longer usable after it leaves the office. There will be no refund offered for products of this nature.

- Updated Information: It is the patient's responsibility to notify Lipogenex of any changes to health, insurance, address, phone number and email.

By signing below you acknowledge that you fully understand and accept the policy of Lipogenex Anti-Aging Center regarding the refunding of purchases.

Name: _____ Date: _____