CONVENTUS

COSMETIC PROCEDURES SUPPLEMENTAL APPLICATION

*****DERMATOLOGISTS:** If you have begun performing NEW laser procedures in the past 24 months, please complete this form. If not, you may sign and date below for completion.

**** ALL OTHER SPECIALTIES: If you do not perform any cosmetic procedures referenced on this application, please sign and date here to complete the form.**

SIGNATURE:____

POLICY NUMBER: ______________________ DATE: __________________________________

COSMETIC PROCEDURES

1. Do you perform (in your office, a surgi-center, a hospital) any of the following procedures:

FACIAL COSMETIC:	# of Procedures
a. Blepharoplasty	______________
b. Facelift	______________
c. Forhead lift	______________
d. Thread Lift	______________
e. Contour Threads	______________
f. Genioplasty	______________
g. Facial implants	______________
h. Rhinoplasty	______________
i. Lip implant/lift	______________
j. Mentoplasty	______________
k. weight loss surgery	______________
l. Soof lift	______________
m. Otoplasty	______________
n. Endoscopic procedures	______________
o. Neck Lift	______________
p.Thermage	______________
q. dermabrasion	______________
r. cosmeceuticals	______________
s. phenol chemical peels (deep)	______________
t. blue chemical peels/TCA (med)	______________
u. micro chemical peels (superficial)	______________
v. Other: ______________	______________

BODY CONTOURING:	# of Procedures
a. Abdominoplasty	______________
b. Buttock implants	______________
c. Calf lift	______________
d. Liposuction	______________
e. Tumescent liposuction	______________
f. upper arm lift	______________
g. thigh lift	______________
h. cellulite treatment	______________
i. stretch mark treatment	______________
j. Malar augmentation	______________
k. Other: ___________	______________

HAIR TREATMENT:	
a. flap surgery	______________
b. laser hair removal	______________
c. hair removal by other than laser	______________
d. hair replacement	______________
e. scalp expansion	______________
f. scalp reduction	______________
g. propecia or rogaine	______________
h. Other: ___________	______________

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BREAST:

a. augmentation	________________
b. mastoplexy	________________
c. implantation/revision /removal/reduction	________________
d. gynecomastia surgery	________________
e. nipple/areola reduction	________________
f. nipple inversion repair	________________
g. Other: ____________________	________________

VEIN TREATMENT:

a. phlebectomy (varicose/spider)	________________
b. sclerotherapy	________________
c. laser treatment	________________
d. injection therapy	________________
e. Other: _____________	________________

INJECTABLES:	**# of Procedures**
a. Mesotherapy	________________
b. Botox	________________
c. Restylane	________________
d. Hylaform	________________
e. Collagen	________________
f. Fat	________________
g. Fillers	________________
h. Spectera	________________
i. Sculptra	________________
J. Radiesse	________________
k. Cosmoplast	________________
l. Juvaderm	________________
m. Other: __________________	________________

LASER:	**# of Procedures**
a. laser or light to cut,seal,vaporize	________________
b. laser resurfacing	________________
c. tumescent liposuction	________________
d. laser hair removal	________________
e. IPL	________________
f. Body contouring	________________
g. Other: _____________	________________

SKIN TREATMENT:	**# of Procedures**
a. Curettage and dessication	________________
b. excisions and/or closures	________________
c. grafting sclerotherapy	________________
d. microdermabrasion	________________
e. Mohs surgery	________________
f. nail surgery	________________
g. microlipoinjection	________________
h. tissue expansion	________________
i. permanent eyeliner	________________
j. tattoo removal	________________
k. cryosurgery	________________
l. IPL treatment	________________
m. radiofrequency treatment	________________
n. flushing and rosacea	________________
m. birthmarks & moles	________________
n. melasma & brown spots	________________
o. Other: ____________________	________________

FEMALE/MALE ENHANCEMENT:	**# of Procedures**
a. phalloplasty	________________
b. labioplasty	________________
c. foreskin reconstruction	________________
d. sex change	________________
e. Other: _____________	________________

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OFFICE BASED SURGERY:

2. I am familiar with the regulations established by the N.J.A.C. to perform office based surgery, and I agree to comply with these regulations in performing all office based surgical procedure cases for which I am the attending physician. In addition, I agree to provide appropriate written discharge instructions to each patient to whom the regulations of office based surgical procedures apply, as described in the N.J.A.C. 13:35-4A.4 as applicable.

_____Yes _____No

3. Which of the above procedures do you perform using:

Local anesthetic: ____
Conscious sedation: ____
IV sedation: ____
General anesthesia: ____

4. Are you accredited by any ambulatory care accrediting agency? If yes, by whom?

____

MEDICATIONS:

5. Do you use, recommend for use or distribute any non FDA approved substances (usually associated with treatment). If so, please list these substances:

____

____

____

5a. Do you compound medications or substances on premises and/or use a compounding pharmacy?

____

6. Please indicate the extent of your formal training in the procedures you have responded "yes" to above, including any specific additional training you have taken since the completion of your residency or fellowship in the areas of Cosmetic Procedures (please include any supporting documents i.e. certificates, accreditation, etc.)

____

____

7. Do you have hospital privileges to perform the procedures above for which you responded "yes" above?

____

If so, please list these hospitals:

____

____

8. Have your hospital privileges as respects the performance of the above procedures ever been reduced, proctored, suspended, restricted, investigated or modified? If so, please provide full details, including the names of hospitals and the dates this occurred.

____

____

____

9. I am familiar with each of the regulations established by the N.J.A.C. to perform cosmetic and alternative procedures, and I agree to comply with these regulations in treating all cosmetic procedure cases for which I am the attending physician. In addition, I agree to provide appropriate written discharge instructions to each patient to whom the regulations of cosmetic and alternative procedures apply, as described in the N.J.A.C. 13:35-4A.6 and N.J.A.C. 13:35-4A.12 as applicable.

_____Yes _____No

10. Do you work at a MediSpa? ____

11. Do you have a relationship with MediSpa? ____

12. If using **INJECTABLES**, where do you get your supply? ______________________________

12a. Are they FDA approved drug manufacturers shipped within the United States? _________

12b. Do you inject any non-FDA approved drugs for the specific treatment you are using it for?
____

12c. Do you provide INFORMED CONSENT specific to the treatment/procedure for:

a. Fillers? ______________
b. Injectables? ______________
c. Label of medications? ______________
d. Cosmetic surgical procedure? ______________

13.Do you employ any of the following:

a. aestheticians? ______________ How many? ______________
b. Skin care specialists? ______________ How many? ______________
c. Physician Assistants? ______________ How many? ______________
d. Nurse practitioners? ______________ How many? ______________
e. RN's or LPN's? ______________ How many? ______________

14. What treatments/procedures do your employees perform?

____

____

15. Are you on premises during the performance of:

a. IPL treatments? ____
b. Laser treatments? ____

16. Do you asses a patient prior to the performance of IPL or laser hair removal treatment by a non-physician employee?

____

17. What is the percentage of patients you treat under the age of 18? ____________________

PLEASE
ATTACH ALL COSMETIC PROCEDURE ADVERTISING MATERIALS AND ANY ADDITIONAL TRAINING DOCUMENTATION

SIGNATURE: ____

POLICY NUMBER: ________________________ DATE: ____________________________