truebalance™
SPA • MEDICAL AESTHETICS • LASER

Dear Patient:

Thank you for your interest in treating your Migraine pain with True Balance Spruce Grove.

Please see the attached form. This is a Migraine Diary. Please fill this out and email it back to us.

You will also need to speak with your Insurance Provider if you are hoping to obtain coverage for this treatment **PRIOR** to booking your Consultation to avoid any unexpected expenses.

You will require a **Special Authorization Form** from your Insurance Provider. **All forms required from your insurance company to ensure eligibility must be completed and emailed to us prior to your appointment along with the Migraine Diary we have included in this email.**

We do not offer any direct billing.

This will be between you and your Insurance Provider. In the event that you are covered, you will not be required to pay any fees after your treatment, unless you are over the age of 65, then you will be expected to pay an injection fee of $114.02 In the event that your Insurance Company does not cover your treatment, we will bill your credit card. Each treatment is $1014.02 taxes included.

You may book your Migraine treatments every 12 weeks. Anything outside of this window will not be covered by Insurance and you will be expected to pay out of pocket.

Once we receive all forms back, we will review them to insure you have met the necessary criteria. We will then contact you to book your consultation with the Physician. This will be a 15 minute in clinic appointment booked on a separate day. From there we can book you in for your treatment. This will be a 30 min appointment booked on a separate day with one of our Nurse Injectors.

Thank you again for choosing True Balance. If you have any other questions or concerns, please let us know!

Sincerely,

Guest Care Services
True Balance Medical Spa

Treatment History for Patient: Chronic Migraine

Patient Name: _____ Date: _____

Is this patient new to BOTOX® therapy for Chronic Migraine? ☐ Yes ☐ No

Length of Time Patient afflicted with Chronic Migraine (ie # of of months or years): _____

Number of Headache/Migraine Days per month: _____ Duration of Headaches/Migraines: _____ ☐ HRS ☐ DAYS

Relevant Diagnostic or Confirmatory Tests Performed

☐ Neurological Consult Date: _____ Comments: _____

☐ MRI/CT Scan Date: _____ Comments: _____

☐ Other (Specify Date and Type): _____

All Prior Relevant Treatments

☐ Non-Opioid Analgesios
Drug Name: _____ Dose: _____ Durration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ Tricyclic Antidepressants
Drug Name: _____ Dose: _____ Durration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ Alpha 2 Agonists
Drug Name: _____ Dose: _____ Durration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ Prednisone
Drug Name: _____ Dose: _____ Durration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ Methysergide
Drug Name: _____ Dose: _____ Durration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ Ergots
Drug Name: _____ Dose: _____ Durration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ Anticonvulsants
Drug Name: _____ Dose: _____ Durration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ Topiramate
Drug Name: _____ Dose: _____ Durration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ Beta Blockers
Drug Name: _____ Dose: _____ Durration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ Calcium Channel Blockers
Drug Name: _____ Dose: _____ Durration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ Opioids
Drug Name: _____ Dose: _____ Durration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ Triptans
Drug Name: _____ Dose: _____ Durration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ OTHER
Drug Name: _____ Dose: _____ Durration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ OTHER
Drug Name: _____ Dose: _____ Durration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ OTHER
Drug Name: _____ Dose: _____ Durration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

Estimated BOTOX® Does to be Administered: _____ Units

Consent: I hearby consent to the collection by the pharmacy of the information on this form as it pertains to my patient to administer the services of the Program. I consent to the disclosure of this information to the Allergen Inc In compliance with the federal and provincial privacy laws, in only aggregate, non-patient identifiable format for the purpose of reposting requirements, program monitoring and evaluation.

Physician Signature: _____

Name of your headache/migraine acute and/or preventive medications (over-the-counter and prescription) both current and past*	How often you took it (per day & per month)	How Much (eg, 25mg Pill)	How long you took it (eg, 3 Months)	How it worked

How to headaches/migraines affect your daily life (work, school, activities, family ect)?

_____

_____

_____

_____

_____

_____

I hereby authorize the release of my medical information to True Balance Medical Spa.

Client Signature: _____ Date: _____