Client: Brianna Caracci (6180) Nov 14, 2025

1. Please note: fields with a red asterisk are mandatory.

Legal First Name: Brianna

Legal Last Name: Caracci

Date of Birth: 6/14/1995 (age 30)

Minor's Guardian Full Name, If Applicable:

Gender: Female

Street Address of Residence: 393 Oxford St

Apt./Unit #: APT 2

City of Residence: Rochester

State of Residence: NY

Zip Code: 14607

Mobile Phone: (585) 259-5339

Email: bncaracci@gmail.com

2. The client allows MedScape GFE to perform the good faith exam and for the good faith exam to be released to: TinyTox Collab

Appointment made? Yes

3. Please state the date and time of the appointment:

11/19/25 1pm

4. Check all treatments to have now or possibly would like in the future below: *Note: MedScape GFE does not determine the treatment route and/or dosages nor prescribes. TinyTox Collab advises on treatment options within their clinic, scope of practice and protocols according to their medical director's guidelines.

☑ Neurotoxin Injections

5. Please answer the questions below relating to the selected treatment(s) above:

Have had selected treatment(s) before? Yes

Result of previous treatment(s)? Excellent results

Goal of requested treatment(s)? Select ALL that apply.

☑ Reverse signs of aging

Area(s) to be treated: *Remember this clearance is for the next year, unless medical conditions modify. Therefore, be aware of other areas to complete in the future: Forehead

If needed, please explain further below:

6. "Yes" was selected for previous treatment(s). Please list treatment(s) history below. If more space is needed please add more rows by hitting the "add rows" button.

	Treatment	Last Treatment
1	Botox	4/5/25

7. Under any type of medical care? (i.e. PCP, OB/GYN, allergist, naturopath, mental health, specialist)

No

8. For female assigned gender at birth:

Currently pregnant? ☑ No

Trying to become pregnant? ☑ No

Could possibly be pregnant? ☑ No

Currently breastfeeding? ☑ No

Going through IVF/Planning on IVF in the near future? ☑ No

9. Please enter the name and location of preferred pharmacy below. If do not have one, please write "none":

NA

10. List ALL medications below including homeopathic supplements and vitamins. If none apply, please write in "none".

	Name of Medication:	Start Date:
1	None	

11. List ALL surgeries and hospitalizations below. This includes ALL implantation of objects placed in the body that one is not born with ie devices, stents, piercings. If none apply, please write in "none".

	Type of Surgery/Hospitalization:	Date and Year of Surgery/Hospitalization:
1	None	

12. List ALL allergies below and/or dietary restrictions. If none apply, please write in "none".

	Type of Allergy:	Reaction:
1	None	

13. Vitals & Measurements

Height (ft/in or cm)
5'6

Weight (lbs or kg)
165

Have you noticed any recent changes in your weight?
No

Do you have personal wellness or body goals you'd like us to know about?
No

If "other", please specify

14. Health History - Circulatory and Respiratory System (Please select all that apply):

☑ None of these

15. Health History - Nervous System (Please select all that apply):

☑ None of these

If "other", please specify

16. Health History - Digestive System (Please select all that apply):

☑ None of these

If "other", please specify

17. Health History - Skin (Please select all that apply):

☑ None of These

If "other", please specify

18. Health History - Other (Please select all that apply):

☑ None of these

If "other", please specify

19. Health History - Cancer

Have you ever been diagnosed with cancer?

No

If yes, please specify type, date of diagnosis, and current status (active, in remission, or treated) N/A for No.

NA

Has any immediate family member (parents, siblings, children) been diagnosed with cancer?

No

If yes, Please specify relation, type of cancer, and age at diagnosis. N/A for No.

If "other", please specify

20. Health History - Mental Health & Emotional Well-Being

Do you have a history of depression, anxiety, or other mental health conditions?

No

If yes, are you currently receiving treatment (medication, counseling, or therapy)? N/A for none.

NA

Have you ever been hospitalized for a mental health condition?

No

If yes, please specify when and which hospital. N/A for none.

If "other", please specify

21. Please answer the lifestyle questions below:

Average stress level:

Moderate

Smoke, vape, or chew tobacco?

None

On average, how many days per week for alcohol consumption?

Occasionally (a few times a month)

Recreational drugs?

None

On average, how many glasses of fluids (including water, juice, and decaffeinated tea) are consumed daily? (Glass = 8 ounces)

Around 4-8 glasses

Currently following any specific diet plan? If so, please specify which one(s): ☑ None of these

22. Approval and/or deferral to medical director's SOPs (description of treatment(s) that client is approved and/or deferred for). Please select all that apply treatments for approved and/or deferred to medical director's SOPs with TinyTox Collab. MedScape GFE does NOT condone any off label administration or dosing of ANY treatments. We will approve, however, it is ONLY depending on if TinyTox Collab's medical director allows for off label treatment(s). For any off label administration and dosage, TinyTox Collab must follow policies and procedures as approved by your clinics medical director. If TinyTox Collab's medical director does not allow for said off label treatment(s), the good faith exam note provided by MedScape GFE's and the high-level provider will be null and void.

Treatment(s) client is approved and/or deferred to receive at TinyTox Collab's (select ALL that apply to visit):

☑ Chemical Peel ☑ Dermal Filler Injections ☑ Dermaplaning ☑ Diamond Glow Facial
☑ Microneedling ☑ Neurotoxin Injections

Treatment(s) deferred to TinyTox Collab's medical director's SOPs with the reason(s) for deferral. If no explanation(s) is/are necessary, please write "not applicable":

NA

Clarification(s) needed from the client before approval. The client MUST resubmit with clarification(s) requested by the good faith exam high-level provider. If the client does not provide what the good faith exam high-level provider requests, the note is void, and therefore, the client is denied. If no explanation(s) is/are necessary, please write "not applicable":

NA

Term(s) of approved treatment(s) (select ALL that apply):

☑ 1 year (unless medical condition(s) change, medication(s) change and/or anything if anything is added to what is stated and approved in this GFE. If any of the aforementioned apply, the client must be re-seen at the time of discovery AND before their next appointment/treatment(s)

Provide treatment name(s) and explanation(s) for short-term approval(s) (under one year approval). If no explanation(s) is/are necessary, please write "not applicable":

NA

e-signature Nov 17, 2025

Good Faith Exam completed by the following MedScape GFE Practitioner:

Danielle Trenelli, FNP-BC

*Signed by Danielle Trenelli on Nov 17, 2025 at 12:12 PM from IP 71.127.239.****