

BEAUTILASE

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Consent Form Skin Tightening / Facial Rejuvenation and Rosacea

Today's Date _____

CLIENT INFORMATION & MEDICAL HISTORY INFORMED CONSENT In order to provide you with the most appropriate treatment, please complete the following questionnaire. All information is strictly confidential.

Name _____ DOB ____/____/____ Age _____ Sex _____

Address _____ City _____

Cell Phone _____ Home Phone _____

E-Mail _____ How did you hear about us? _____

Area To Be Treated _____

Medical Information: Do you have any of the following medical conditions? (Please TICK all that apply)

- | | | |
|------------------------------------------------|--------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Vitiligo | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Hormone Imbalance |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Thyroid Imbalance |
| <input type="checkbox"/> Herpes Simplex | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Blood Clotting Disorder |
| <input type="checkbox"/> Frequent Cold Sores | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Keloid Skin Lesions |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Auto- Immune Disorder | | |

Are you currently under the care of a Physician or Dermatologist? Yes / No If yes, Provide Details

Do you have any other current or past health problems or medical conditions? Yes / No If yes, Provide Details

Please list any known allergies, and/ or past allergic reactions:

Have you had any surgeries? Yes / No If yes, Provide Details

Current Medications Please list all oral and topical medications you are presently taking: (including anti-biotics, hormone therapy, blood thinners, mood altering medications, 'over the counter' medications)

Please list all vitamins and/or herbal supplements you are presently taking:

Have you ever had any of the following?

- | | | | |
|---------------------------------------------|----------------------------------------------------|--------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> IPL Treatment | <input type="checkbox"/> Photofacials | <input type="checkbox"/> Fractional Laser |
| <input type="checkbox"/> Electrolysis | <input type="checkbox"/> CO2 Laser | <input type="checkbox"/> Lase Surgery | <input type="checkbox"/> Cosmetic Surgery |
| <input type="checkbox"/> Waxing | <input type="checkbox"/> Collagen or Other Fillers | <input type="checkbox"/> Botox or Dyspot | <input type="checkbox"/> Facials |
| <input type="checkbox"/> Tweezing | <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Threading |

Are there any other laser or skincare treatments you are interested in:

Client Lifestyle

- | | |
|-----------------------------------------------------------|----------------------------------------------------------|
| Do you smoke? _____ How often? _____ | Have you had any recent tanning or sun exposure |
| Do you drink? _____ How often? _____ | that changed the colour of your skin? Yes / No |
| Are your activities mostly indoor or outdoor? Circle one. | Have you recently used any self-tanning lotions of spray |
| How many times a week do you exercise? _____ | tans/treatments? Yes / No |
| Do you use tanning beds? Yes / No | |

For our female patients only:

- Are you currently on Birth Control? Yes / No
- Are pregnant or lactating? Yes / No
- Are you trying to become pregnant? Yes / No
- Are you nursing? Yes / No
- Did you get hyperpigmentation or pregnancy mask during your pregnancy? Yes / No
- Are you menopausal? Yes / No
- When was the last day of your last menstrual period? _____
-

The Candela GentleYAG is a device that produces a beam of high-intensity light that penetrates deeply into the skin tissue, where it delivers a controlled amount of targeted therapeutic heat. The upper layers of your skin are protected with a cooling burst of cryogen. Together the long pulse laser and cooling device offer optimal treatment with minimal side effects.

The following points will be discussed with me during my individualised consultation

(Please Initial Each Line):

Additional anesthetic techniques are the use of a compounded numbing cream that contains Tetracaine, Betacaine and Lidocaine and can be applied to the treatment area thirty minutes prior to laser treatment.

- _____ Some discomfort may be experienced during laser treatment.
- _____ Common side effects include temporary redness and mild “sunburn” like effects that may last a few hours to 3-4 days or longer.
- _____ Serious complications are rare but possible.
- _____ Other potential risks include but not limited to **crusting, blistering, itching, pain, bruising, burns, infection, scabbing, scarring, swelling, and failure to achieve the desired result.** May take 1-3 weeks or more to heal

_____ During the healing process there is a slight possibility that there might be a **Pigment changes**, including **hypopigmentation (lightening of the skin)** or **hyperpigmentation (darkening of the skin)** lasting **1 to 6 months or longer** surrounding skin. This is usually a temporary condition; however, on a rare occasion, it can be permanent.

_____ Full treatment schedule process such as waiting period is 4-weeks in-between treatments and the expected results.

_____ I understand that I may require more than one treatment to obtain the results I desire.

_____ This depends on the severity and condition of my skin. I have been informed that after laser treatment I will avoid sun for 1-3 months and wear a SFP 30. In the first few days after treatment I will not scrub or use abrasive skin cleansers.

_____ I understand that if I've had **sun exposure** or used a **tanning bed within a 3-day period** pre or post treatment I risk a possible pigment change or blistering.

_____ I understand that **sun or tanning lamp exposure, the use of self-tanning creams**, and not adhering to the after treatment instructions provided to me may increase my chance of complications.

_____ Once any of these conditions have healed, the treated area may still be sensitive to the sun for an additional two to four weeks, or possibly longer in some patients.

_____ On rare occasion there may be a client that does not respond to treatment.

_____ Most people resume regular daily activities immediately following treatment. **You should not take hot baths, hot showers, or engage in vigorous exercise for two (2) weeks following your laser leg vein treatment.**

_____ Lasers can cause eye injury and protective eyewear must be worn during treatment. We will provide this.

_____ To minimize the chance of complications the pre and post care instructions must be followed carefully.

_____ The Laser used by BEAUTILASE may feel like a "snapping of rubber bands" followed by the brief sensation of heat and or sensation of the laser/DCD spray.

I permit photographs and digital images being taken to evaluate treatment effectiveness, for medical education and training. No photographs or digital images revealing my identity will be used without my written consent. If my identity is not revealed, these photographs and digital images may be used, shared, and displayed publicly without my permission.

I freely consent to the proposed treatment. I hereby release BEAUTILASE, from any liability arising out of the services associated with the above treatment. Before and after treatment instructions have been discussed with me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction. All my questions have been answered. By signing below, I certify that I have read and fully understand this consent form as well as the Exclusionary Criteria listed.

I certify that the preceding medical, personal, and skin history are true and correct. I am aware of the above stated BEAUTILASE policies and will abide by them. I am aware that it is my responsibility to inform BEAUTILASE of any medical changes, health changes, skincare regime, new or changed medications, or recent sun exposure as this will alter the results of my treatment. A current medical history is essential for the caregiver to execute the appropriate treatment procedures.

I UNDERSTAND AND ACKNOWLEDGE THAT PAYMENTS FOR THE ABOVE TREATMENTS ARE NON REFUNDABLE AND NON EXCHANGEABLE. THIS INCLUDES ANY PACKAGE DEALS WE OFFER.

Client Signature: _____ Print Name: _____ Date: _____

Therapist: _____ Print Name: _____ Date: _____