BEAUTILASE

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Consent Form
Vein Removal

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)

__ Cancer
___ Vitiligo
___ Hepatitis
__ Diabetes
___ Pacemaker/Defibrillator
___ Hormone Imbalance
__ High Blood Pressure
___ Paralysis
___ Thyroid Imbalance
__ Herpes Simplex
___ Muscle Weakness
___ Blood Clotting Disorder
__ Frequent Cold Sores
___ Neurological Disorder
___ Keloid Skin Lesions
__ HIV/AIDS
___ Arthritis
___ Eczema
__ Depression
___ Seizure Disorder
___ Psoriasis
__ 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 of 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?

__ Laser Hair Removal ___ IPL Treatment ___ Photofacials ___ Fractional Laser

__ Electrolysis ___ CO2 Laser ___ Lase Surgery ___ Cosmetic Surgery

__ Waxing ___ Collagen or Other Fillers ___ Botox or Dyspot ___ Facials

__ Tweezing ___ Chemical Peels ___ Microdermabrasion ___Threading

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

____

____

Client Lifestyle

Do you smoke? _________ How often? _______

Do you drink? __________ How often? _______

Are your activities mostly indoor or outdoor? Circle one.

How many times a week do you exercise? _________

Do you use tanning beds? Yes / No

Have you had any recent tanning or sun exposure that changed the colour of your skin? Yes / No

Have you recently used any self-tanning lotions of spray tans/treatments? 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 by wearing a SFP 30 or above. 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:______________