BEAUTILASE

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Consent Form **PLASMA PEN**

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 _____Occupation
_____

E-Mail Address _____ 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	___ Surgery	___ Cosmetic Surgery
__ Waxing	___ Botox or Dyspot	___ Facials	___ Collagen or Other Fillers
__ Tweezing	___ Chemical Peels	___Threading	___ Microdermabrasion

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 following points will be discussed with me during my individualised consultation

It is imperative to clearly mark and notate any area on this form you wish to discuss further prior to treatment. It is your responsibility to fully understand the procedure and expected outcomes before the treatment starts

Please read carefully and initial ONLY when you feel comfortable to proceed. Ensure all points below have been fully discussed and understood.

When initialling and::or signing, you are stating that you understand and accept the terms of this treatment.

• You have chosen a cosmetic procedure that is not medically necessary. _____

• Plasma Skin Tightening cannot guarantee an exact shrinkage result due to individual skin elasticity and healing process. _____

• You can have additional to get desired results. Dependent on the area of treatment, additional treatments cannot be performed sooner than 4 weeks or later than 8 weeks after the initial and subsequent visits. It is important for the area to fully heal prior to additional treatments. _____

• The skin type of each client is different and the healing process may lead to mild discoloration of the skin. Green Peel treatments may be suggested after the healing process is complete. _____

• After each treatment, swelling and redness may occur. Some guests may experience extreme swelling. _____

• The treatment includes a small burn to the skin, you may experience a smell of charring. This is completely normal. _____

• You must adhere strictly to the specific aftercare advice provided to you following your treatment. Doing so is extremely important and will greatly reduce the risk of post procedural infection upon leaving the Salon. _____

• Treated area must heal properly. Picking, plucking, scrubbing or manipulating the treatment area could make the treatment area appear uneven, discoloured or scarred, requiring further work. ____

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:_____