Informed Consent for Microdermabrasion

Client's name:___________________________________ Date:__________________

To the CLIENT: You have a right to be informed about your condition and its treatment, so that you make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give, or withhold, your consent for treatment.

1. I voluntarily request that ___________________________ (and such associates, technical assistants and other skincare professional she or he may deem necessary) to perform the Microdermabrasion procedure. I acknowledge having been informed that this cosmetic procedure is intended to remove surface layers of the skin to improve the vitality of the skin.

2. I understand that my skincare professional can discover other, or different conditions that may require additional or different procedures than those planned. If my skincare professional discovers such other or different conditions I will be referred to appropriate medical care provider.

3. I acknowledge that, while the goal of such a procedure is the removal of damaged skin, the realistic results average 50-75% improvement. I acknowledge that the practice of cosmetology is not an exact science and that no specific guarantees can or have been made concerning the expected result. Some clients are improved and in others no appreciable improvements is noticed.

4. I also realize that the following risks and hazards may occur in connection with the particular procedure; worsening or unsatisfactory appearance, creation of additional problems such as: poor healing or skin loss, nerve damage, painful unattractive scarring, or recurrence or the original condition.

5. I have been advised that I must use sunscreen of SPF 25 or greater at all times through out the course of treatment.

6. I have been informed that there are risks such as loss of blood and infection that are attendant to the performance of any exfoliation procedure.

7. I have been advised of alternative methods available for my treatment, which includes acid peels and laser skin resurfacing.

8. I acknowledge my obligation to follow the written and spoken instructions covering my pre and post treatment skincare regimen.

9. I understand that multiple treatments may be required. The cost of these was disclosed prior to the first treatment.

10. I have received a thorough explanation of my pre-exfoliation and post-exfoliation instructions. I understand these instructions and have received copies for reference. I understand that should I have additional questions, I should not hesitate to call.

ACKNOWLEDGMENT:

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks.

I Consent to the taking of photographs during the course of my laser therapy for the purpose of medical education. These photographs may be used for teaching or publication, as the case provider deems appropriate with a full respect to compete personal identity confidentiality.

CANCELATION POLICY:

48 hour cancelation policy … if for whatever reason you can't make a scheduled appointment please call us and let us know 2 days in advance. If you fail to show for a scheduled appointment without prior notice; a $20 charge will be levied on your account and the session will be considered as completed.

I hereby release Norma Khal and SilkySkin Aesthetic Laser Center from all liabilities associated with the above indicated procedure.

Client/Guardian Signature________________________________Date______________

Laser Technician Signature_______________________________Date______________

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate laser treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name____ Today's Date__________________

Date of Birth____________Age___________Occupation_____________________E mail: __________________

Home Address______________________ City___________________________________ State___ Zip Code______

Home Phone: ( ) - Cell ( ) - Work Phone ( ) -

Emergency Contact Name and Phone____

How were you referred to us? ____

Which of the following BEST describes your skin type? (Please circle ONE skin type)
Type I Always burns, never tans, light color hair and eyes
Type II Usually burns, tans with difficulty, light skin, light colored hair
Type III Sometimes burns, but usually tans, darker eyes, slight coloring to the skin
Type IV Rarely burns, tans easily, dark eye color, definitive darkening skin color
Type V Very rarely burns, dark hair and eye color
Type VI Very dark skin color, dark coarse hair, dark eyes

Do you regularly use tanning salons or sun bathe?___________ If yes; how often?_____________

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

Have you recently used any self-tanning lotions or treatments? □Yes □No

Do you form thick or raised scars from cuts or burns? □Yes □No

Do you have Hyper pigmentation (darkening of the skin) or Hypo pigmentation (lightening of the skin) or marks after physical trauma? □Yes □No If yes, please describe: _____________________________________

* ONLY answer these questions if you are interested in laser hair removal

Have you ever had laser hair removal? ❑Yes ❑No

Have you used any of the following hair removal methods in the past six weeks?

❑Shaving ❑Waxing ❑Electrolysis ❑Plucking ❑Tweezing ❑Stringing ❑Depilatories

Method	Area(s)	Method	Area(s)
Shaving		Depilatories	
Tweezing		Electrolysis	
Waxing		Laser	
Other:		Other:	

MEDICAL HISTORY

Are you currently under the care of a physician? ❑Yes ❑ No

If yes, for what:____

Are you currently under the care of a dermatologist? ❑Yes ❑No

If yes, for what:____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? ❑Yes ❑No

Do you have any of the following medical conditions? (Please check all that apply)

❑Cancer ❑Diabetes ❑High blood pressure ❑Herpes ❑Arthritis

❑Frequent cold sores ❑HIV/AIDS ❑Keloid scarring ❑Skin disease/Skin lesions

❑Seizure disorder ❑Hepatitis ❑Hormone imbalance ❑Thyroid imbalance

❑Blood clotting abnormalities ❑Any active infection

Do you have any other health problems or medical conditions? Please list: ____

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced) ❑Food ❑Latex ❑Aspirin ❑Lidocaine ❑Hydrocortisone ❑Hydroquinone or skin bleaching agents ❑Others**:**____

MEDICATIONS

What oral medications are you presently taking? ❑Birth control pills ❑Hormones

❑Others (Please list): ____

Are you on any mood altering or anti-depression medication?________________________________

Have you ever used Accutane? ❑Yes ❑No, If yes, when did you last use it?_________________

What topical medications or creams are you currently using? ❑ Retin-A® ❑Others (Please list):

____

What herbal supplements do you use regularly?____

Female client:

Are you pregnant or trying to become pregnant? ❑Yes ❑No Are you breastfeeding? ❑Yes ❑No

Are you using contraception? ❑Yes ❑No

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature____ Date:_______________

AFTER CARE FORM

1. Immediately after the treatments, there should be redness and bumps at the treatment area, which may last up to 2 hours or longer. It is normal for the treated area to feel like sunburn for a few hours. You should use a cold compress if needed. If any crusting, apply antibiotic cream. Some physicians recommend aloe vera gel or some other after sunburn treatment such as Desitin. Darker pigmented people may have more discomfort than lighter skin people and may require the aloe vera gel or an antibiotic ointment longer.

2. Makeup may be used after the treatment, unless there is epidermal blistering. It is recommended to use new makeup to reduce the possibility of infection. Just make sure that you have moisturizer on under your makeup. In fact, moisturizer will help the dead hair exfoliate from the follicle, so use moisturizer frequently and freely on the treated area. Any moisturizer without alpha-hydroxy acids will work.

3. Avoid sun exposure to reduce the chance of dark or light spots for 2 months. Use sunscreen SPF 25 or higher at all times throughout the treatment and for 1-2 months following.

4. Avoid picking or scratching the treated skin. DO NOT USE any other hair removal methods or products on the treated area during the course of your laser treatments, as it will prevent you from achieving your best results.

5. You may shower after the laser treatments, and use soap, deodorant, etc. The treated area may be washed gently with a mild soap. Skin should be patted dry and NOT rubbed. You may apply deodorant after 24 hours.

6. Anywhere from 5-30 days after the treatment, shedding of the hair may occur and this may appear as new hair growth. This is not new hair growth, but dead hair pushing its way out of the follicle. You can help the hair exfoliate by washing or wiping with a washcloth.

7. Hair re-growth occurs at different rates on different areas of the body. New hair growth will not occur for at least three weeks after treatment.

8. Call your physician's office with any questions or concerns you may have after the treatment

Please note: Stubbles, representing dead hair being shed from the hair follicle, will appear within 10-20 days from the treatment date. This is normal and will fall out quickly.