Dr. K's Med Spa

Laser Hair Removal & Anti Aging Center

HYDRAFACIAL TREATMENT

CLIENT CONSULTATION AND RELEASE FORM
Please read carefully, complete, sign and date this form prior to your treatment.

Name: _____ **DOB:** _____

Section 1: Medical Information

Do you have any of the following allergies?

____ Shellfish
____ Aspirin
____ Sulfur

Other (Please list): _____

Check if applicable	**Contraindications**

_____ Accutane or other similar medication
_____ Autoimmune disease, HIV, lupus, hepatitis
_____ Blood thinners – Heparin, Coumadin, Warfarin
_____ Breast feeding, pregnancy
_____ Cancer or post-cancer treatments
_____ Cold sores or fever blisters without pre-medication
_____ Cosmetic injections, fillers, or implants, (Botox, collagen)
_____ Eczema, psoriasis
_____ Facial waxing services w/in 7-14 days
_____ Heart disease
_____ Laser procedures, chemical peels, microdermabrasion
_____ Lymphatic disorder
_____ Pacemaker or metal implants
_____ Recent accident or serious injury
_____ Rosacea
_____ Retin-A, Retinol
_____ Skin abrasions or lesions
_____ Skin-lightening or bleaching agent
_____ Thyroid conditions
_____ Type 1 diabetic

Section 2: Client Consent Form

(Initial each acknowledgement line below)

_____ I acknowledge that I have not used Accutane or any medication for the same purpose during the last 12 months.

_____ I acknowledge that if I have ever had a cold sore or fever blister, I should consult with my physician or pharmacist for a pre-use medication to help avoid a possible breakout. That medication should be used each day for two days before, same day, and two days after any aggressive facial exfoliation .

_____ I acknowledge that there is not guarantee that dark discoloration of skin will be reduced or fade. Pigmentation may improve or darken with successive treatments. I acknowledge the need for proper skin care home regimen.

_____ I acknowledge that my skin might experience temporary irritation, tightness, redness or slight swelling which usually dissipates within 72 hours depending on skin sensitivity.

_____ I have disclosed my history of allergies above.

_____ I acknowledge that if I am allergic to one or more of the ingredients in the products used, I may experience allergic reactions.

_____ I acknowledge that if I fail to use a minimal sunscreen (SPF 30) and follow the direction for use, I am more susceptible to sunburn, sun damage & hyperpigmentation. I should avoid excessive sun exposure, especially between 10AM – 2PM.

_____ I acknowledge that this treatment is strictly an elective cosmetic procedure and that no medical claims have been expressed or implied.

_____ I acknowledge that I should avoid use of aggressive exfoliation, waxing, and products containing acids that are not part of the recommended take-home regimen for 2-4 weeks following the treatment.

_____ I acknowledge that I am not pregnant/lactating.

_____ I hereby agree to have the treatment performed and agree to follow all pre and post treatment instructions.

_____ I acknowledge that I have answered all questions truthfully and completely.

_____ I release Dr. K's Med Spa, the provider, and staff of all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products.

_____ I consent to the use of my before, during and after facial procedure photographs for education, promotion, or advertising purposes. My name will not be used to identify these photographs without my written approval.

By Signing below, I certify that I have read and fully understood the contents of this consent form, and the information I provided above are complete, accurate, and up to date to my knowledge.

Client Signature: _____ Date: ____/____/____

Operator Signature: _____ Date: ____/____/____