CONSENT TO LASER/LIGHT ENERGY TREATMENT

NAME _____ **DATE of BIRTH** _____

ADDRESS _____

CELL PHONE _____ **WORK PHONE** _____ **EMAIL** _____

SKIN TYPE: Review the Fitzpatrick Scale skin types below and check the one that best describes your skin. This information will help your technician determine the most appropriate way to approach your treatment(s):

- ☐ I. Very fair skin; blonde or red hair; light colored eyes; freckles common.
- ☐ II. Fair skinned; light hair, light eyes.
- ☐ III. Common skin type; fair; eye and hair color vary.
- ☐ IV. Mediterranean Caucasian skin; medium to heavy pigmentation.
- ☐ V. Mideastern skin; rarely sun sensitive.
- ☐ VI. Black skin, rarely sun sensitive.

Are you of Asian heritage (Class V) and/or have a history of keloid scarring?

- ☐ Yes
- ☐ No

TECHNICIAN: _____

PROCEDURE(s): _____

BENEFIT INTENDED _____

I elect to receive the laser/light energy system procedure(s) indicated above for the stated benefit intended. I understand that outcomes may vary, including 1) good results in one session; 2) good results but only after additional sessions; 3) no results; and in rare cases 4) adverse results. I understand that other treatments to enhance outcomes may be recommended, including, but not limited to, the application of skin care products.

Pre-Procedure and Aftercare Instructions: I have received, and will strictly adhere to, all pre-procedure and aftercare instructions. I understand that for those with more color in the skin, it is advised to use a lightening agent leading up to the procedure to suppress the melanin in the skin. I understand there may be an extended period of recovery following the procedure(s), and that aftercare compliance is crucial for healing, prevention of scarring, hyper-pigmentation and hypo-pigmentation. I understand that particularly avoiding sun exposure after the procedure is crucial to reduce the risk of color change and will always apply a broad spectrum SPF 25 or higher, as recommended by my technician. I understand that initially, the skin treated may be red and swollen,

that fine, thin scabs may form, and that the healing process typically takes anywhere from one to three weeks. However, I am aware that in rare cases, depending on my skin sensitivity and recovery capacity, healing could take as long as three to six months.

Warning: Treatment is not available to clients who are on **ACCUTANE and PHOTOSENSITIZING** medications. In addition, clients using **ANTICOAGULANTS** must disclose this to the technician, as treatment may need to be modified to mitigate additional risk associated with the use of these drugs. For women of childbearing age: You confirm that you are not pregnant and do not intend to become pregnant during the course of treatment. Furthermore, you must keep your technician informed should you become pregnant during the course of treatment.

Risks of care: I understand that the following problems may occur with treatment:

1. **Scarring**: This treatment can create bruising and a moderate burn or blister to the skin. For an effective treatment, the power (joules) needs to be just below the blistering point which means the skin will be red. There is a risk of scarring.
2. **Pigmentation**: The treated area may become either lighter (hypo-pigmented) or darker (hyper-pigmented) in color. This is rare and is usually just temporary, however may become permanent.
3. **Infection**: Although infection following this treatment is unusual, bacterial, fungal, and even viral infections can occur. Herpes Simplex virus infections around the mouth can occur following a treatment, even if there is no past history of Herpes Simplex virus infections in the mouth area. Clients with a history of Herpes Simplex virus in the treated area are encouraged to seek preventative therapy. Should any type of skin infection occur, additional treatment, including antibiotics, may be necessary.
4. **Bleeding**: Pinpoint bleeding is rare but can occur following some laser treatment procedures. Should bleeding occur, additional treatment might be necessary.
5. **Skin tissue pathology**: Energy directed at skin lesions may potentially vaporize the lesion. Laboratory examination of the tissue may not be possible. Only clearly benign pigmented lesions can be treated. A doctor's clearance should be obtained in the case of this type of treatment.
6. **Allergic reactions**: In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations, have been reported. Systemic reactions (which are more serious) may result from prescription medicines. Allergic reactions may require additional treatment. Due to skin surface disruption, irritation and histamine reactions may also occur resulting in itching, dermatitis, or other forms of sensitivity.
7. **Vision damage**: I understand that exposure of the eyes to light during the procedure could damage vision. I will keep the proper eye protection on at all times.

I certify that this consent has been fully explained to me, that I have read the above paragraphs, and that I elect to receive the laser/light energy procedure(s) indicated above. I understand the various risks associated with the Procedure(s) and the importance of properly following pre-procedure and aftercare instructions to minimize those risks. I consent to my photograph being taken before and after the procedure(s).

CLIENT / GUARDIAN SIGNATURE: _____ **DATE**: _____

TECHNICIAN SIGNATURE: _____ **DATE**: _____

NOTICE: Occasionally, unforeseen problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

V-IPL Informed Consent Form

Patient Information

First and Last name:
_____

D.O.B:_____
___

Address:
_____

Phone / Mobile:
_____

E-mail:
_____
____

How did you hear about us?
_____
____

Health Questionnaire:
Have you today or in the past experienced any of the following:

Active/Chronic Conditions:
- ☐ Yes

☐ No Specify: _____

Surgeries/Hospitalization:
☐ Yes
☐ No Specify: _____

Medication Care:
☐ Yes
☐ No Specify: _____

Sensitivity to Medication:
☐ Yes
☐ No Specify: _____

Allergy:
☐ Yes
☐ No Specify: _____

Pregnancy:
☐ Yes
☐ No

Under age of 18:
☐ Yes
☐ No

Exclusion Criteria from treatment (contraindications):

Check any of the statements that apply to you:

☐ Cardiac pacemaker, defibrillator, or other implanted electronic device
☐ Any diseases which may be stimulated by light or heat (such as Herpes Simplex)
☐ Impaired immune system (such as HIV) or use immunosuppressive medications
☐ Sunburns, exposure to sun or artificial tanning during the past 3-4 weeks prior to treatment
☐ Hepatitis or liver disease
☐ History of bleeding coagulopathies, or use of anticoagulants (blood thinning medications)
☐ High or low blood pressure (with medications)
☐ Epilepsy
☐ Hormonal disorders or endocrine disorders (such as polycystic ovary syndrome or diabetes), unless under control
☐ Suffering from Keloid scars or impaired wound healing

- ☐ Vitiligo or tendency to hypopigmentation
- ☐ Current or history of cancer, any cancer drug therapy (such as Ducabaxine, Fluorouracil,
- ☐ Methotrexate, etc), pre-cancerous lesions or problematic moles
- ☐ History of local or recurrent skin infection
- ☐ Fragile, extra dry and sensitive skin
- ☐ Any active skin disease or inflammation (such as Herpes, Psoriasis, Eczema, rash) in the treatment area
- ☐ Metal implants in the treatment area
- ☐ Undiagnosed lesions in the treatment area
- ☐ History or current tattoo or permanent makeup or nevi present in the treatment area
- ☐ Use of Accutane (Isotretinoin, Roaccutane) within the past 3-6 months
- ☐ Breast-feeding
- ☐ Use of photosensitive medication or herbs within 2 weeks prior to treatment (such as Isotretinoin, tetracycline, or St. John's Wort)
- ☐ Tretinoin – Retin A in the last 2 weeks
- ☐ Any synthetic filler procedures (i.e. silicon) in the treatment area. Please note that some of the fillers are "heat resistant". In these cases, treatments may start two weeks after the filler procedure
- ☐ Botox injections in the past 5-7 days
- ☐ Chemical peel or natural fillers in the past 2 weeks
- ☐ Deep chemical peel / laser peel in the past 6 months

1. I _____ duly authorize _____ and other specially trained personnel of this facility, to perform treatment using light based technology systems from Bare Beauty

2. I do not suffer from Herpes / I suffer from Herpes and I agree to initiate preventive treatment with antiviral medications, though I am aware that preventive treatment does not ensure total prevention of Herpes appearance during the treatment.

3. I hereby declare that I was informed in regards to the following:

3.1 The versatile treatments available with Bare Beauty light based systems are based on a principle called selective photothermolysis. The light emitted and absorbed by targeted chromophores (light sensitive molecules) encourages a specific biological process to achieve the desired clinical result.

3.2 I have been advised in regards to possible risks and side effects of the

treatments which may include slight pain, erythema, edema, color changes (hyper or hypo- pigmentation), paradoxical unwanted hair growth and burns. All side effects are transient and mild, however in the event of adverse side effects the treating personnel must be informed and a physician consult may be necessary.

3.3 I am aware that exposure to sun 3-4 weeks prior and after treatment are contraindicated to the treatment and may promote side effects. I was advised to use SPF30 in between treatments.

3.4 I was advised about the use of protective goggles and I agree to wear them throughout the duration of the treatment.

My questions regarding this procedure have been answered to my satisfaction. I accept all risks of treatment and agree to provide aftercare as directed by this facility.

Client's Name	**Signature**	**Date**

For patients under the age of 18:

Guardian's Name	**Relation to patient**	**Signature**	**Date**

Treating personnel Declaration:

Treating personnel's Name	**Signature**	**Date**

This consent was accepted by me, after I explained to the client all the above and I confirm that all of my explanations were understood by her/him.

_____

CANCELLATION/NO-SHOW POLICY

If you are unable to make your appointment, we kindly ask that you call 24 hours in advance to avoid a cancellation fee. Cancellations less than 24 hours in advance will result in a $30 fee and no-show appointments will be charged the total amount of service missed. You receive a reminder text as a courtesy, but it is your responsibility to call if you need to cancel or reschedule and to make sure it's not within 24 hours of your appointment or you will be charged.

If you are more than 15 minutes late to your appointment, you may need to reschedule to accommodate other clients that are scheduled after you.

A credit card or debit card is required to reserve your appointment. The card will be charged only if there's a failure to follow our cancellation policy.

Thank you for your understanding,

Bare Beauty

I have read and agree to the terms of the NO-SHOW/CANCELLATION POLICY

_____ _____

NAME (Please print) SIGNATURE

_____ _____ _____

CREDIT CARD # EXP. CVV

*NO REFUNDS AND TREATMENTS ARE NON-TRANSFERABLE