

BEAUTILASE

34 Target Road, Glenfield 09 442 2603 / 021 169 4975 smita@beutilase.co.nz

Consent Form

LASER HAIR 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 _____ 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)

- | | | |
|--|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Vitiligo | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Hormone Imbalance |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Thyroid Imbalance |
| <input type="checkbox"/> Herpes Simplex | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Blood Clotting Disorder |
| <input type="checkbox"/> Frequent Cold Sores | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Keloid Skin Lesions |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> 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 or 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?

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> IPL Treatment | <input type="checkbox"/> Photofacials | <input type="checkbox"/> Fractional Laser |
| <input type="checkbox"/> Electrolysis | <input type="checkbox"/> CO2 Laser | <input type="checkbox"/> Lase Surgery | <input type="checkbox"/> Cosmetic Surgery |
| <input type="checkbox"/> Waxing | <input type="checkbox"/> Collagen or Other Fillers | <input type="checkbox"/> Botox or Dyspot | <input type="checkbox"/> Facials |
| <input type="checkbox"/> Tweezing | <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Threading |

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

Client Lifestyle

- | | |
|---|--|
| Do you smoke? _____ How often? _____ | Have you had any recent tanning or sun exposure that changed the colour of your skin? Yes / No |
| Do you drink? _____ How often? _____ | Have you recently used any self-tanning lotions of spray |
| Are your activities mostly indoor or outdoor? Circle one. | tans/treatments? Yes / No |
| How many times a week do you exercise? _____ | |
| Do you use tanning beds? 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

(Please Initial Each Line):

- _____ Serious complications are rare but possible.
- _____ Common side effects include temporary redness and mild “sunburn” like effects that may last a few hours to 3-4 days or longer.
- _____ Some discomfort may be experienced during laser treatment.
- _____ Treatment options (brown or black hair responds best, number of treatments).
- _____ Full treatment schedule process such; as waiting period in-between treatments and the expected results.
- _____ It generally takes 10 to 21 days after the procedure for the treated hair to fall out.
- _____ **Pigment changes, including hypopigmentation (lightening of the skin) or hyperpigmentation (darkening of the skin) lasting 1 to 6 months or longer may occur.**

_____ Freckles may temporarily or permanently disappear in treated areas.

_____ Other potential risks include but are not limited to, **crusting, blistering, itching, pain, bruising, burns, infection, scabbing, scarring, swelling, and failure to achieve the desired result.**

_____ I understand that this procedure works on the growing hairs and not on dormant hairs. For this reason, complete destruction of all hair follicles from any one treatment is unlikely, and I understand that I will require several CONSECUTIVE treatments to obtain a significant, long-term reduction of hair growth. I also understand some people may not experience complete hair loss even with multiple laser procedures and some people may require more treatments than the initial series. I also understand that I will need maintenance treatments to keep the growth away. This can be contributed to skin type, genetics, underlying hormonal issues, medication or resistant hair.

_____ An average of between 8 – 12 treatments is recommended to obtain maximum results. The number of actual treatments required will vary per the unique characteristics of the individual being treated. Cosmetic medicine and skin therapies are not exact sciences and the results of treatments cannot be guaranteed.

_____ On rare occasion there may be a client that does not respond to treatment.

_____ Future hormonal changes may cause additional hair growth.

_____ The skin needs to be cleaned and shaved 1-2 days prior to laser hair removal treatment.

_____ **Exercise** is to be **avoided 24 hours before and after** laser treatment.

_____ Lasers can cause eye injury and protective eyewear must be worn during treatment.

_____ I understand that **sun or tanning lamp exposure, the use of self-tanning creams**, and not adhering to the after care treatment instructions provided to me may increase my chance of complications.

_____ To minimize the chance of complications the pre and post care instructions must be followed carefully.

_____ The Laser used by Beutilase 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: _____