CONSENT TO ADVANCED or CLASSIC ESTHETICS 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): This Informed Consent to Treat applies to two classifications of Esthetics care: Advanced Esthetics Services and Esthetic Classic Services. **Check the type of esthetic services below** applicable to you. Check both if you anticipate receiving treatment under both categories. Consult your technician if you have questions about the nature of treatment anticipated for you.

- ☐ **Advanced Esthetic Services:** Which includes Esthetic peels up to 40%, electrology, needling/collagen induction therapy, non-invasive ultrasound, and hand-held cryotherapy.

- ☐ **Esthetic Classic Services:** Which includes Body contouring, cellulite reduction, radio frequency, and high frequency treatments.

I elect to receive the esthetics procedure(s) indicated above. I declare that I am over the age of 18, not under the influence of drugs or alcohol, not pregnant or nursing, not on blood thinners or blood pressure medication, and

am not an insulin-dependent Diabetic. I understand that if I am under the age of 18, Parental Consent is required for me to obtain these procedures. Under no circumstances may I have these services if I am under the age of 14. I represent that the stated date of birth is truthful on this form.

I understand that many medications and some diseases and disorders may either contraindicate me for treatment or affect the results. I understand I should continue taking my medications, and tell my technician about all prescription and non-prescription drugs, supplements, topically applied products, eye drops, etc. that I use or take. I understand that due to the nature of this treatment, results cannot be predicted, and I acknowledge that no guarantees have been made as to the results that may be obtained.

Warning: Treatment is not available to clients who are on *Accutane*. 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. Clients with a pacemaker, internal defibrillator, or metal implants must disclose this to the Technician as this may contraindicate them for treatment. 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.

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.

General Risks of Procedure(s): I understand there are risks associated with my procedure, including, but not limited to: minor burns, blistering, hypopigmentation (lightening of the area), hyperpigmentation (darkening of the area), swelling, allergic reactions, bruising, scarring, pin-point bleeding, pimple-like bumps, dry skin, tingling, and other similar side effects and/or reactions. I understand these risks also include, but are not limited to, the following:

1. **Scarring**: This treatment can create bruising and a moderate burn or blister to the skin. Depending on treatment received, more serious side effects may include, skin indentations or subcutaneous fat loss, and open sores that lead to infection.
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. **Skin tissue pathology:** Only clearly benign pigmented lesions can be treated. A doctor's clearance should be obtained in the case of this type of treatment. Treatment directed at abnormal lesions can cause malignant cells to develop and laboratory examination of the tissue specimen may not be possible.
5. **Allergic reactions**: Due to skin surface disruption, irritation and histamine reactions may also occur resulting in itching, dermatitis, or other forms of sensitivity. In rare cases, local allergies to topical preparations have been reported.

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 advanced esthetic 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.

CLIENT SIGNATURE: _____ **DATE**: _____

For patients under the age of 18:

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-ST Informed Consent Form

Patient Information

First and Last name: _____

D.O.B.: _____

Address: _____

Phone Number: _____

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/metallic device
- ☐ Use of drugs that influence the immune system
- ☐ Impaired immune system (such as HIV)
- ☐ Any endocrine disorder (such as diabetes)
- ☐ Active or recent malignancy (cancer)
- ☐ Uncontrolled thyroid disease
- ☐ Hepatitis or liver disease
- ☐ Blood coagulopathy or excessive bleeding or bruising
- ☐ Use of blood thinning medications (anticoagulants), including fish oil, garlic supplements, etc.
- ☐ History of deep vein thrombosis in the treatment area
- ☐ Heat induced diseases (Herpes, etc) in the treatment area
- ☐ Any active skin disease in the treatment area (such as herpes, eczema, rash)
- ☐ Extra dry or sensitive skin
- ☐ Sunburns in the treatment area
- ☐ Suffering from Keloid scars or impaired wound healing
- ☐ Tattoo or permanent makeup in the treatment area
- ☐ Use of Accutane within the past 6 months
- ☐ Any aesthetic or medical surgery in the treatment area in the past 3 months
- ☐ Breast-feeding in the past 3 months
- ☐ Any synthetic filler procedures (i.e. silicon) in the treatment area (Please note that some of the fillers are "heat resistant." In these cases, ST Handpiece 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 associate technicians of this facility, to perform treatments

using the ST Handpiece.

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 ST Handpiece are based on RF technology, implemented in the medical applications for over 3 decades. RF utilizes different frequencies flowing through the skin with the purpose of heating the dermis and hypodermis layers. The heat promotes the production of collagen fibers which are the main proteins in the skin responsible for skin elasticity and resilience thereby contributing to healthier and flexible skin. In addition, RF induced heat increases stored fat break down. The treatment is noninvasive.

3.2 I have been advised of the expected results as well as the possible risks and side effects of the treatment which may include local pain, erythema, edema, itching and sensitivity to touch, urticaria, purpura or ecchymosis, hematoma, allergic contact dermatitis to the glycerine oil or acoustic contact gel, bruise, blister, burn, hyper- and hypo-pigmentation. 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.

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

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.

_____