Refine Aesthetics

CLIENT INFORMATION/MEDICAL HISTORY

Name _____Age_____ Date_____

Address_____City_____State_____Zip_____

Email Address_____

Cell_____ Date of Birth_____

Emergency Contact_____Relationship_____Cell_____

Medications (Prescriptions/over the counter med, vitamins, herbal medications)

_____

_____

Drug Allergies_____

Major Surgeries/Facial surgeries_____

Ongoing facial treatments? (Injectibles/Laser/chemical peels/waxing/facials)_____

Please circle if you have any of the following conditions –

Heart Disease Excessive Bleeding High Blood Pressure Hepatitis Skin Cancer Liver Disease

Lupus Auto-Immune Disorders Diabetes Neuromuscular Disease Cold Sores/Fever Blisters

Lidocaine allergy/sensitivity

Pregnant? Y N Breastfeeding? Y N

The above information is true and accurate to the best of my knowledge.

_____

_____ _____

Client Signature **Date**

Refine Aesthetics

Use of Photographs for Before/After Comparison

Explanation –

This consent form authorizes Refine Aesthetics to use these photographs for before and after comparison after treatment. Under no such circumstances will any publications or material bear your name. Your refusal to consent to the use of these photographs for before/after comparison will in no way influence your treatment.

Consent –

I understand the photographs taken of me shall be used for my medical records showing before/after comparison. If in the judgement of the medical health care professional they would benefit in educating others who are seeking the same treatment, I give my consent for Refine Aesthetics to publish said photos. All photos will only show area treated.

I waive the rights that I may have to any claims for payment or royalties in connection with any exhibition, televising or publication of these photographs.

I release and hold harmless Refine Aesthetics, the staff and consultants from any liability in connection with the use of such materials.

I understand that this consent is subject to the following limitation – Under no circumstances will any such publication, film photograph, video tape or material exhibited contain my name unless voluntarily disclosed by me.

_____ _____

Signature of Client **Date**

DIAMOND GLOW™

PATIENT CONSENT FORM

DiamondGlow™ is a next-level skin resurfacing technology that simultaneously exfoliates, extracts, and infuses skin with targeted serums to address specific skin quality concerns.

Please review and initial the following statements prior to your DiamondGlow™ treatment:

____ I acknowledge that I might experience a scratchy, stinging sensation during the treatment. This sensation will subside during the post-treatment protocol shortly after the treatment is finished.

____ I understand that if I fail to use sunscreen, I am more susceptible to sunburn and hyperpigmentation.

____ I acknowledge that I have not been on medication for acne therapy during the past 6 months.

____ I acknowledge that I have not been using retinoids or any other exfoliating products for the past 3 days and I will discontinue the use of retinoids for 1 to 3 days after the procedure.

____ I acknowledge that facial telangiectasia (small blood vessels) is sometimes more apparent immediately after the treatment when the skin is thin and will diminish after my skin has recovered from the treatment.

____ I agree to remove my contact lenses prior to the procedure (if applicable).

____ I have informed my skin care specialist that I am prone to cold sores and I am currently not experiencing an outbreak. I acknowledge that any area around the mouth or face that is prone to cold sores will be avoided during the treatment (if applicable).

____ I understand that the skin care specialist performing the treatment uses tools that are either disinfected or disposable.

____ I acknowledge that my skin may experience temporary tightness, mild erythema (redness), or slight swelling, which should dissipate in a few hours following the treatment.

____ I understand if I am **pregnant**, **lactating**, have **rosacea**, **salicylate/aspirin sensitivity**, or an outbreak of any skin condition, I should consult with my physician prior to receiving the DiamondGlow™ treatment.

I hereby agree to have the DiamondGlow™ treatment performed on my skin by a trained operator and to follow all post-treatment protocols.

Print name: _____ **Date:** _____

Signature: _____ **Date:** _____

Uses

The DiamondGlow™ device is a general dermabrasion device that gently removes the top layer of skin and delivers topical cosmetic serums onto the skin.

Please see back page for Important Safety Information and the SkinMedica® Pro-Infusion Serums Disclaimer.

DIAMOND GLOW™ / SKINMEDICA®

Important Safety Information

The DiamondGlow™ treatment is not for everyone. You should not have a DiamondGlow™ treatment if you have compromised skin quality. Tell your provider if you are pregnant or lactating, or if you have any medical conditions, including allergies, and if you are using topical medications on the area to be treated.

Typical side effects include a scratchy, stinging sensation during the treatment and temporary tightness, redness or slight swelling after the treatment. Rare serious side effects may also occur and include severe skin irritation and allergic reactions.

SkinMedica® Pro-Infusion Serums Disclaimer

SkinMedica® Pro-Infusion Serums are intended to meet the FDA's definition of a cosmetic product, an article applied to the human body to cleanse, beautify, promote attractiveness, and alter appearances. These products are not intended to be drugs that diagnose, treat, cure, or prevent any disease or condition. These products have not been approved by the FDA and the statements have not been evaluated by the FDA.

Please talk to your provider for additional information.