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

MICRO-NEEDLING CONSENT FORM

Name_____Date_____

I authorize _____to perform Micro-channeling/Micro-needling on my skin, and to apply topical preparations as determined necessary.

I understand that Micro-channeling/Micro-needling is non-ablative skin rejuvenation and involves the creation of perforations in my skin to promote healing responses to rejuvenate my skin. I understand that the procedure is performed with an automatic perforating device and that clinical results may vary. This treatment is designed to create a controlled wound to deeper layers of the skin while leaving healthy tissue surrounding the injury in order to enhance collagen production with minimal downtime. I understand there is a possibility of short-term effects such as reddening, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as infection and scarring. I will also seek medical attention as recommended by Refine Aesthetics if necessary and understand that I am responsible for the full payment of expenses incurred in the event this is necessary.

These effects have been fully explained to me.

Clinical results may vary depending on individual factors, including medical history, amount of sun damage or textural problems, skin type, and my compliance with pre/post treatment instructions.

I understand that the Micro-channeling treatment may involve a series of treatments and the fee structure has been fully explained to me.

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I am not pregnant at this time. I also have completed a medical history checklist and have been informed about what I must do and not do before, during, and after the procedure. I do not have a history of Keloid or hypertrophic (raised) scars. I do not have a history of getting dark areas when my skin is injured. (Also known as hyper pigmentation.)

I consent to the taking of photographs and authorize their anonymous use for the purposes of clinical audit, education and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

I expressly agree that this consent, waiver and indemnity agreement is intended to be as broad and inclusive as permitted by the laws in the State of Colorado. I have read this consent and understand all its terms, and execute this release voluntarily and with full knowledge of its significance.

_____ _____

Client Signature Date

Refine Aesthetics

MICRO-NEEDLING QUESTIONNAIRE

Name_____ Date_____

Do you have a history of uncontrolled diabetes? Y N

Are you allergic to steel? Y N

Do you have a history of hemophilia? Y N

Have you used Accutane in the last 6 months? (Medicine for acne) Y N

Do you have any keloid scarring? (Raised scarring) Y N

Do you have a history of any chronic skin disease such as eczema or psoriasis? Y N

A YES to any of the above questions is a hard contra-indication to micro-needling.

Are you over 18 years of age? Y N

Have you taken aspirin or any other blood thinners in the past 7 days? Y N

Do you have a history of cold sores, herpes or fever blisters? Y N

Are you sensitive or allergic to Latex? Y N

Do you have trouble healing? Y N

Have you had a chemical peel, laser, Botox, fillers in past 1-2 weeks? Y N

Are you currently using Retin-A or other exfoliating skin care products? Y N

Are you currently taking any anti-inflammatory or steroid medications? Y N

Are you allergic to any anesthetics? Lidocaine? Prilocaine? Tetracaine? Y N

Do you have a history of skin sensitivity? Y N

Are you currently taking Vitamin A or E in any form? Y N

Are you currently undergoing radiation/chemotherapy? Y N

Are you pregnant or breastfeeding? Y N

Are you currently being treated by a dermatologist? Y N

Presence of any raised moles, warts, or lesions in treatment area? Y N

Do you have hyper-pigmentation? Y N

Are you a smoker? Y N

Do you have a history of HIV? Y N

Have you ever been diagnosed with Hepatitis? Y N

Have you ever been diagnosed with any heart conditions? Y N

Do you have any questions on the Micro-needling procedure? Y N

_____ _____

Client Signature Date