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**

THE PERFECT DERMA™

A chemical peel, RX

The Perfect Derma Peel Consent Form

The Perfect Derma Peel is a medium depth, medical grade chemical peel suitable for all skin types. The peel contains Trichlorocacetic Acid (TCA), Retinoic Acid, Kojic Acid, Salicylic Acid, Phenol, Glutathione and Vitamin C.

Contraindications:

- Patients who are pregnant or breast feeding
- Patients with an allergy to any peel ingredient listed above, or to aspirin
- Patients who have used Accutane within the past 4 months
- Patients who have open wounds, sunburn, infected skin, cold sores or lesions. Patients with a history of cold sores (herpes simplex) may be given an antiviral 3 days prior to the peel
- Patients who have recently had treatments such as waxing, electrolysis or chemical exfoliants
- Patients who are undergoing chemotherapy and/or radiation therapy
- Patients with a history of an autoimmune disease or any condition that may weaken the immune system

Please read and initial the following:

_____ Prior to receiving treatment, I have informed my medical professional about any medications or health conditions that may contraindicate this treatment.

_____ I understand that there might be some discomfort such as stinging, redness, burning, itchiness or tightness during and a week after the treatment. I understand that it is important not to pull, pick at or remove peeling skin forcibly.

_____ I understand that there is no specific guarantee as to the final results of the peel, and that I may require more than one treatment for optimal results.

_____ I understand that while complications are extremely rare, they may occur. In the event of a reaction or complication, I agree to immediately contact my medical professional for follow up care.

_____ Occasionally hyper pigmentation or hypo pigmentation may develop which can persist for weeks or months after the treatment.

_____ I understand that post peel care includes use of Mineral Perfection SPF 30 or an SPF 30 or above and avoid sun exposure during the exfoliation process.

_____ I understand that extended sun exposure, including use of tanning beds, is prohibited both before and after The Perfect Derma Peel treatment. Avoid sweating excessively or use of steam/sauna for 3 days post peel.

_____ I understand that this is an elective procedure and is non refundable.

_____ I understand that no other chemical peels or medical device treatments are to be performed on my skin until my medical professional releases me to do so.

Patient signature _____ Date _____

Medical Professional _____ Date _____

bella medical products