Consent Form

Fibroblast Pre and Post Procedure Instructions

How Does Fibroblast Treatment Work?
The plasma fibroblast treatment is a relatively new innovation in the beauty industry in North America but has been used for a number of years in the medical field and in Europe. This device ionizes gases near the skin to create a tiny lightning bolt of energy or electrical arc. This thermal energy instantly shrinks the targeted skin and vaporizes a small portion of the superficial skin layer. The tissues retract and tighten giving you more youthful and glowing skin.

How Long Does It Last?
The plasma fibroblast sublimates or vaporizes skin, which means the skin volume is actually reduced. This is a soft surgery procedure with effects that should last as long as you might expect with invasive surgery. Of course, the effects of plasma fibroblast are not entirely permanent as it does not stop any further aging, but the positive results should last for several years depending on the area treated. The rejuvenating effects of treatment will be noticeable immediately after the first session, but the final results will be seen at 8 weeks. For some, an additional treatment may be required after 8 weeks has elapsed for maximum results. Additionally, there are lifestyle factors that can individually affect one's results such as smoking, alcohol consumption, and regular sun exposure.

How Many Treatments Are Required?
Most patients see significant improvement with one session. The number of treatments required will vary according to the area being treated, depth of wrinkles and sagging and other factors. Most patients see instant improvement and this continues to build incrementally over the course of the following 8 weeks. Further treatments can be carried out to achieve even further improvement. Appointments must be spaced out by 4-8 weeks at a minimum.

Day of Treatment
On the treatment day, it is recommended that no makeup is worn on the treatment area. Plasma fibroblast cannot be performed on any part of the eye area if you are wearing lash extensions due to risk of infection. You may take an antihistamine 30 minutes prior to your appointment to help with swelling and continue to take antihistamines and anti-inflammatory medications like ibuprofen for 2-3 days following your appointment. Swelling is a normal and expected part of the healing process. Anti-inflammatory medicines should be discontinued a week prior to the session because they increase the chance of excessive bleeding.

A numbing solution is left on the skin for approximately 30 minutes. When the treatment area is sufficiently numb, the session will begin. You may feel some heat in the treatment area or an itchy sensation. Expect to spend at least 30-60 minutes at your appointment, depending on the size of the area being addressed.

Pre-Treatment:

- It is recommended that sun protection of SPF 30-50 be used daily for at least 2 weeks prior to the Plasma Lift treatment(s).

- Vitamin A derivatives such as tretinoin, Retin-A or any type of alpha hydroxy acid will increase sensitivity. These products should be discontinued two weeks prior to treatment.

- Stay out of the sun and avoid tanning salons or the use of any self-tanning products for 3 weeks prior and post treatment session.

- As a patient, I understand that all treatment, medical history, hold harmless and waiver forms must be completed and signed to ensure that I understand the potential benefits and risks associated with the plasma fibroblast procedure.

- Before and after photographs will be taken by the technician at the appointment as well as at a follow up session to track your skin's progress.

Aftercare:

- If you feel particularly uncomfortable, anti-inflammatories such as Advil and Motrin (ibuprofen) or antihistamines such as Benadryl are suggested. It is up to the individual to decide on the appropriate medication. Exercise should be avoided immediately following the procedure and up to 24 hours after.

- As part of our healing response it is natural for the treated area to become swollen as the body rushes nutrients to the area. The delicate eye area will experience significant swelling.. Ice packs can be used 20 minutes on and 20 minutes off to help with swelling discomfort. Downtime can vary depending on your natural rate of recovery. Most people find the healing process only lasts a few days. In some cases (generally if clients do not follow pretreatment and post care instructions), the swelling can last several days longer and can interfere with vision if the treatment was performed in the eye area.

Initially after treatment and up to 3 days later, there may be occasional weeping in the treatment area. This is the natural healing response to the plasma fibroblast procedure. As the treated area begins to heal, you will notice the carbon crusts begin to dry out and eventually flake out. This can take up to 10 days, but it is important to let the crusts fall off on their own.

DO NOT PICK the scabs as it can lead to infection, hyperpigmentation and scarring. It is important to keep this area clean with gentle cleansing. It is strongly advised that you use an SPF 30-50 sunscreen (throughout the year including the colder months) to avoid sunburn as the area's sensitivity to sunlight will be heightened for up to 6 months post plasma fibroblast procedure.

DO NOT use alcohol-based cleansers as this will slow down the healing process by removing moisture from the skin. If at any time the treated area becomes excessively hot, red or shows signs of pus, please contact us or your physician immediately to assess if you have an infection

Swimming and sauna activities are only permitted 2 weeks post treatment and once all the crusts have fallen off the skin and the wound is completely healed and closed. Smokers have a dampened healing response and reduced circulation or blood flow. Because of this there is an increase in the risk of infection and slowed healing. After the crusts are gone, a slight redness may remain in the following weeks and possibly months. It usually takes 4-6 weeks (sometimes longer) for the skin to regain its normal color again.

ABOVE ALL ELSE, DO NOT SCRATCH or PICK!

I, ______________________________, have read and understand the above information and of my own free will I choose to move forward with my procedure.
Signature: ____________________________________Date: _____________________

Consent Form

Fibroblast Release Form / Liability Waiver

I hereby consent to and authorize ___________________________ to perform the following treatment:

____

I recognize that individual results may vary and not all potential complications can be delineated. I fully accept the risks inherent in this procedure and have been informed of potential complications that can occur with this treatment. I understand that more than one treatment may be necessary to achieve my desired results at an additional cost.
I have read and fully understand the post care guidelines. I understand that if instructions are not followed I increase the risk of an undesirable outcome in this treatment. In the event that I may have questions or concerns regarding my treatment or post care instructions, I will contact the practitioner immediately.

I have also, to the best of my knowledge, provided accurate information concerning my medical history, including all known allergies, prescription drugs, supplements and any other products I am currently consuming.

I have read and fully understand this agreement and all information detailed above. I understand the treatment and accept the risks. All my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold the technician (nor the establishment), whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today. I also release ____ of any liability that may arise from this procedure.

Client Name (Printed)

____

Client Name (Signature)

____Date________________________

Fibroblast Pre and Post Procedure Instructions
Date: _______________ Name: ____ Date of Birth: ____________________________ Address: __________________________________ City: _________________________ State: __________________ Age: ________ Phone #: (______) _________________ Email: ____
Known allergies and reactions:

____

List current medications (topical & oral):

____

Please check any of the following that apply:

Cancer		Eczema	
Diabetes		Immune Disorder	
Hysterectomy		Skin Disease/Disorder	
AIDS/HIV		Varicose	
Psoriasis		Veins/Phlebitis	
Spinal Injury		Pacemaker/Defibrillator	
Keloid Scarring		Thyroid Disorder	
Menopause		Blush/Redden Easily	
High/ Low Blood Pressure		Depression/Anxiety	
Claustrophobia		Bruise Easily	
Hormone Imbalance		Lupus	
Hepatitis A/B/C		Fibromyalgia	
Rosacea		Circulation Disorder	
Cold Sores		Metal Implants/ Pins	
Blood Clot Disorder		Heart Disease	

1. Do you smoke? Y / N
2. Are you pregnant? Y / N
3. Do you form keloid scars? Y / N
4. Are you currently wearing eyelash extensions? Y / N
5. Do you wear contacts? Y / N
6. Do you follow a special diet? Y / N
7. What is your daily intake of Water? ______oz. Caffeine? _____oz. Alcohol? ______oz.
8. Are you currently under the care of a physician or dermatologist for any medical condition? Y / N If so, explain.

____

9. Any surgeries within the last 6 months? Y / N If so, explain.

____

10. Have you received dermal injections, fillers or Botox within the last 6 months? Y / N If so, explain.

____

11. Are you currently using any products that contain Retin-A, Renova, Adapalene, Alpha Hydroxy Acids, Tretinoin, Differin, Glycolic Acid, Salicylic Acid, Lactic Acid, Retinol, Vitamin A, Accutane or any other prescription or over the counter skin product? Y / N
12. Have you used any of these products in the past 3 months? Y / N If so, explain.

____

13. Have you ever had any allergic reaction to any skincare products? Y / N If so, explain:

____

Client Consultation:

I understand, have read and completed the questionnaire with accuracy. I agree that this form is a full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications, side effects and an undesirable outcome from the treatment received. I am aware that it is my responsibility to inform the practitioner of my current medical or health conditions and to update this history. I understand that the services offered are not a substitute for medical care and any information provided by the practitioner is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the practitioner in giving better service and is completely confidential. The treatments I receive here are voluntary and I release ____ and_________________________________ from any liability and assume full responsibility thereof.

Patient Signature ____Date: ____________

Practitioner Signature ____Date: ____________

Name: ________________________________ Date of Birth: ________________________________

Address: ________________________________ Phone: _____________________________________

Email Address: ________________________________

Photographic Consent: I consent to photographs being taken before, during and after each procedure. I agree to these photos being stored electronically in my case file and will be used only with my written consent for promotional purposes.

Patient Signature: _______________________________________Date: _____________________

Patch Test Waiver:

(please initial where appropriate) (A) I understand that a skin test can determine whether or not I will experience a reaction to the products used within 48 hours prior to the treatment. However, I accept this will be inconclusive as to whether I have an allergic reaction at any time in the future. I therefore waive my option to an allergy test and wish to proceed with treatment. ________ (B) I have undergone or been ordered an allergy test prior to my initial treatment. I therefore release (practitioner name/company) _____________ from liability related to any allergic reaction I may experience associated with either the application of the pretreatment cream or any other products used before, during and after my procedure, immediately or at a later date. _________

Patient Signature: _______________________________________ Date: _____________________

In case the case of an emergency , please contact:

Name: _______________________________ Number: ___________________________

Relation: ______________________________