Medical History and Consent

Full Name: _____
Date:_____
Email:_____
Phone(____)_____Address:_____
How were you referred to our facility?
_____

Current Medications (please list) _____
Have you taken Accutane within the last year? Y / N
_____

Allergies (please list):
_____

Please Read Carefully - Have you had or do you currently have any of the following? Indicate YES with an (X)

____Cancer
____Cold Sores
____Contact Lenses
____Latex Sensitivity / Allergy
____Epilepsy

____Tattoo / Permanent makeup

____High or Low Blood Pressure

____Hemophilia

____Problems with Healing

____Botox Treatment

____Chemical Peels

____Laser Resurfacing

____Plasma Pen Treatment

____Cosmetic Surgery

____Heart Condition
____Diabetes
____Dermatitis / Eczema
____Hypoglycemia
____Hepatitis

____HIV / Aids

____Keloid Scars

____Thyroid Disease

____ Iron deficient / Anemic

____Injectable Fillers

____Glycolic Acid

____Pregnant / Nursing

____ Pacemaker

*** If you suffer from any of the above, it is important that you notify your technician so that they can can take the necessary precaution to ensure you receive the best treatment to avoid any risks to your health.**

Additional Notes:

_____

PLEASE READ CAREFULLY AND INITIAL / SIGN WHERE INDICATED. Ensure all points below have been discussed with the technician. You are signing to state that you understand and accept these terms.

1. I acknowledge that any information contributed by me is true, to the best of my knowledge and that the present condition of the area that has been treated or will be treated is stated on this record. I fully understand that Pure Esthetics NY Skincare Studio only provides beauty services; There is no medical treatment involved. Plasma Pen Treatment is an art - not an exact science - and cannot guarantee an exact shrinkage result due to skin elasticity and individual healing process. Please be advised results may be different from one individual to another. (Initial Here)_____

2. I understand that I may be required to return for additional treatments before the overall procedure is deemed complete. The payment for any additional work, (if applicable), will be agreed prior to the treatment commencing. Depending upon area of treatment, additional treatments cannot be performed until after 6-8 weeks from the initial treatment date to allow sufficient healing time. (Initial Here)_____

3. I realize that with any beauty service there may be certain risks, which must be understood. I will be fully responsible for any and all results, which may arise from these beauty services. I do hereby agree to hold Pure Esthetics NY Skincare Studio free from any and all claims or suits for damage, for injuries or complications resulting from any beauty services provided by Pure Esthetics NY Skincare Studio. I understand that any spot removals / skin revision work performed may result in minor scarring and or loss or gain of natural skin pigment.
(Initial Here)_____

4. The skin type of every client is different and the healing process may lead to some discoloration of the skin. It is imperative that the Aftercare provided is followed. Microdermabrasion or skin rejuvenation may be advised, after the healing process is complete. (Initial Here)_____

5. I understand that the taking of before and after photographs of the said procedures is a condition of such procedure. I grant permission for the use of the photographs, or electronic media images as identified, in any presentation of all kinds. (Initial Here)_____

6 I have received pre and post procedure instructions with the care kit and will strictly adhere to them. I understand that my failure to do so may jeopardize my chances for a successful procedure outcome. (Initial Here)_____

7. I understand the importance of my accurate and complete medical history. I understand that withholding any medical information may be detrimental to my health and safety during and after the procedure. I understand that if there is any change in my medical history it is my responsibility to inform the technician. (Initial Here)_____

8. I am aware that any skin altering procedures such as Laser treatments, plastic surgery, implants, injectables and weight gain or loss may alter the treatments look. (Initial Here)_____

I, the client, agree with all points listed and discussed, and wish to proceed as recorded. I participated fully in the decision for the selected area or areas intended for my Plasma Pen Treatment. I certify I have read and initialed the above paragraphs. I have had it explained to my understanding therefore I consent to this procedure. I accept full responsibility for the decision to receive this treatment.

Client's Full Name
(PRINTED):_____
Client Signature:_____Date(M/D/Y):_____

Treatment Agreement

I, the trained technician, confirm I have checked all paperwork including consent forms and medical history, I have discussed all procedure points with my client and they understand all elements of the Plasma Pen Treatment. Aftercare advice has been verbally presented to the client and written instructions will be provided.

Technician Signature: _____Date: (M/D/Y) _____