Confidential Medical Profile

Patient info:

First Name:_____ Last Name:_____

Date of Birth: _____/_____/_____

Phone Number:_____E-mail:_____

Address:_____

Emergency Contact Info:

Emergency Contact #1:

First Name:_____Last Name:_____

Phone Number:_____ Relationship:_____

Emergency Contact #2:

First Name:_____Last Name:_____

Phone Number:_____ Relationship:_____

To avoid unforeseen complications, it is very important that you answer the following questions honestly and to the best of your knowledge.

Do you have or previously had any of the following: (Check mark YES or NO and explain where necessary.

YES NO 18 Years of age or older
YES NO History of MRSA (methicillin-resistant Staphylococcus aureus)
YES NO Botox (Last Treatment_____)
YES NO Diabetes- [Type 1 OR Type 2]
YES NO Hepatitis - A C B D
YES NO HIV Positive
YES NO Forehead/ Brow Lift/ Facelift/ Nova string
YES NO Easy Bleeding
YES NO Alcoholism
YES NO Abnormal Heart Condition (Explain:_____)
YES NO Taking medications including immunosuppressive, such as anti-inflammatory or steroids.
YES NO Chemical or Laser Peel (Last Treatment_____)
YES NO Are you pregnant or nursing?
YES NO Brow Lash Tinting (Last Treatment_____)
YES NO Cancer (Type:_____ Year_____)

YES **NO** Are you currently or have you ever undergone Chemotherapy/ Radiation
(How long in Remission _____)
YES **NO** Tumors/Growths/Cysts
YES **NO** History of skin diseases or remarkable skin conditions or sensitivities?
YES **NO** Oily Skin
YES **NO** Currently taking Accutane or acne treatment (Type:_____)
YES **NO** Currently taking Vitamin A or Vitamin E in any form?
(Explain:_____)
YES **NO** Tan by booth or salon
YES **NO** Taking blood thinner such as: Aspirin, Ibuprofen, Alcohol, Coumadin, etc.
(currently or within the last 7 days)
YES **NO** Allergic reaction to any medications such as Lidocaine, Tetracaine, Epinephrine, Dermacaine, Benzyl Alcohol, Adverse reaction to dentist treatment, Carbopol, Lecithin,Propylene Glycol, Vitamin E Acetate, other:_____
YES **NO** Allergies to metals, latex, food, topical anesthetic, other:_____
YES **NO** Do you use skincare products containing Retin-A, Glycol Acid, or Alpha Hydroxyl?
YES **NO** Are you currently under the care of a physician? (Explain:_____)
YES **NO** Have you taken any mood altering drugs in the last 8 hours? (Explain:_____)
YES **NO** Do you have problems with healing? (Explain:_____)
YES **NO** Any diseases or disorders not listed:_____

Circle all that apply:

Heart conditions, Allergies to make up, Keloid or Scars, Stroke, Chest pain, Shortness of breath, Alopecia, Epilepsy,Seizures, Refractive eye surgery, Glaucoma, Trichotillomania, Hepatitis, HIV, Jaundice, Kidney disease, Darkening of skin, Rosacea, Eczema.

Please list any medications you are currently taking including (natural supplements):_____
_____

Are there any other medical conditions that we should be aware

of:_____

I agree that all the above information is true and accurate to the best of my knowledge and accept that it is my responsibility to consult with my physician and obtain the appropriate doctors notes for any contradiction that I believe may exist prior to undergoing this procedure

Signature:_____ Date:_____

Informed Consent and Release Agreement

Plasma Fibroblast / Microneedling / Mesotherapy

I,_____, acknowledge that I have been given all the necessary information about the Plasma Fibroblast / Microneedling / mesotherapy procedure including expected results, inherent risk and after care to make an informed decision on whether or not to undergo a this procedure.

_____I certify that I am over the age of 18 and in a position to make an informed decision.

_____I understand there may be a certain amount of discomfort of pain associated with the procedure.

_____I understand that possible side effects include temporary bleeding, bruising, swelling, redness

_____Although Plasma Fibrobast / Microneedling / Mesotherapy is effective in most cases, no guarantee can be made that a specific client will benefit from the procedure

_____The Microneedling procedure is the process of causing tiny injuries into the dermis

_____Mesotherapy sloughs off the surface layer of the skin and aids in better absorption of facial products

_____Plasma Skin Regeneration (PSR) or fibroblast technology is a non-invasive advanced skin tightening enhancement procedure. It is a great alternative to invasive treatment and requires less down time.

_____All instruments that enter the skin or come in contact with body fluids are single use, individually packaged, sterile, disposable, and are properly disposed of after use. Cross contamination guidelines are strictly adhered to. I certify that my technician used sterile, single use, individually wrapped cartridge that were opened in front of me.

_____Generally, the results are excellent. However, a perfect result is not a realistic expectation. It is usual and advised to expect a series of treatments. Your technician will recommend a treatment plan specifically for you.

_____I have received pre and post procedure instructions and I will follow those directions. I understand that failure to follow these instructions could jeopardize my results.

_____I understand that face altering cosmetic surgery procedures such as laser hair removal, Botox, fillers, implants, collagen and other face procedures may alter the results of my Plasma Fibroblast / Microneedling / Mesotherapy treatment.

_____I understand that Retin A, Renova, Alpha Hydroxy and Glycolic Acids must NOT be used on

treated areas for a minimum of 6 weeks.

_____ I understand that tanning beds, pools, some skin care products and medications can affect my results.

_____ I understand that if there is a medical condition that I may have that I am unsure about, I will take responsibility for consulting with my physician and obtaining a doctor's note prior to undergoing this procedure.

I understand that the process of Plasma Fibroblast / Micro Needling / Mesotherapy is not always a one step process and may require multiple treatments over multiple subsequent visits to achieve and maintain the desired results.

I understand that skin conditions can change over time due to circumstances beyond our control (Metabolism, skin type, medicine, age, smoke, alcohol, sun exposure, Glycolic acid or Retin-A, and or other factors).

I acknowledge that the proposed procedure(s) involve risks inherent in the procedure, and have possibilities of complications during and/or following the procedure such as: infection, hyper-pigmentation and hypo-pigmentation to name a few.

I have been quoted the cost of today's appointment, and the cost of the following sessions. Client must allow 6-10 weeks between treatments to ensure skin has had enough time to heal.

This agreement will remain in effect for this procedure and all future procedures conducted by this Technician. If there has been a change in my health the client must advise the technician, and refill consent form.

I certify that I have received home care instructions with instructions on proper home care.

I read and fully understand English fluently and understand that this consent agreement is legal and binding. I have read and fully understand all information in this agreement.

I'll certify that I have read or have had read to me the Contents of this form. I understand the risk and alternatives involved in this procedure(s). I have had the opportunity to ask questions, and all of my questions have been answered. I acknowledge that I have reviewed and approved the material given to me, and I authorized as my technician to perform on my body the Plasma Fibroblast / Microneedling / Mesotherapy procedure desired today.

Client full name:_____

Client Signature:_____ Date:_____ DOB:_____

Client (Driver's license or Government ID#)_____ Expiration date:_____

Recommended Procedure and number of Treatments:_____

Technician printed name:_____

Technician Signature:_____Date:_____

Plasma Fibroblast / Microneedling / Mesotherapy

Consultation Report

Record of Consultation

Date:_____/_____/_____ Name:_____

Address:_____ City:_____

Phone Number:_____

How did you hear about us?_____

Desired-Results:_____

_____

Which of the following best describes your area of concern (check all that apply):

- ❑ Hyperpigmentation
- ❑ Reducing the appearance of wrinkles and loose skin
- ❑ Reducing the appearance of large pores
- ❑ Reducing the appearance of stretchmarks
- ❑ Acne scarring or healed scars
- ❑ Uneven skin tone
- ❑ Other please explain:_____

For Technician Use only

Recommended Procedure/ Treatment:_____

Technician Name:_____ Technician Signature:_____

Client's Signature_____

Photography Release Consent Form

First Name:_____Last Name:_____

Phone Number:_____ E-mail:_____

I, _____,certify that i allow use of my photographs: YES NO

I, _____, certify that i am over the age of 18: YES NO

I,_____, assign to Christine Alvarez RN and Down Town Beauty Bar the right to copyright photography: YES NO

I,_____, hereby consent to and authorize the use and reproduction of photography by Christine Alvarez RN and Down Town Beauty Bar LLC and my technician which you have taken of my procedure. Any proofs can be used for any purpose whatsoever by Christine Alvarez RN and Down Town Beauty Bar LLC and my Technician without further authorization from me or compensation to me. All photos shall constitute your Property, solely and completely owned to Christine Alvarez RN and Down Town Beauty Bar LLC.

I certify I have read the information and above content to my full understanding. Therefore giving all ownership and copyright ownership over to Christine Alvarez RN and Down Town Beauty Bar LLC. I understand this agreement is non-revocable and Permanent starting on the date on which you signed.

Client Signature:_____

Date::_____

Incident Report

RECORD OF INCIDENT

Date:

Name: _____

Address: _____

City:

Phone Number: _____

Area of Incident:

Incident Details: _____

_____

_____

_____

Treatment: _____

Recommended Follow Up:

_____

Technician Name:

Technician Signature: _____