Informed Consent for Treatment

Client Name:_____ Today's Date:_____

Home Address_____ City_____ State _____Zip Code _____

Home Phone (____)_____ Work Phone (____)_____

I hereby (1) agree to assume full responsibility for any and all injuries or damage which are sustained or aggravated by me in relation to my receiving of the Services, (2) release, indemnify, and hold harmless the Company, its direct and indirect parent, subsidiary affiliate entities, and each of their respective officers, directors, members, employees, representatives and agents, and each of their respective successors and assigns and all others, from any and all responsibility, claims, actions, suits, procedures, costs, expenses, damages, and liabilities to the fullest extent allowed by law arising out of or in any way related to the Services, and (3) represent that: (a) I have no medical or physical condition that would prevent me from receiving the Services, (b) I do not have a physical or mental condition that would put me in any physical or medical danger, (c) I have not been instructed by a physician to not receive Services, (d) no warranty or guarantee, or other assurance, has been made to me covering the results of the Services, (e) knowing the risks involved I nevertheless chose to voluntarily request the Services. Notwithstanding the foregoing (and by way of illustration only and not limitation) if any of the following apply to me or if I'm unsure for any reason, I hereby acknowledge the Company's recommendation that I consult a medical physician before receiving Services.

Cryoskin, Vela Shape, Laser Hair Reduction, Vanquish Fat Removal, MicroNeedling, Cryotherapy:

This procedure requires more than one treatment. The total number of treatments will vary between individuals. On occasion there are patients that do not respond to treatments.
Alternative methods are waxing, shaving, electrolysis, and chemical epilation.
I understand. I understand that there may be some discoloration to skin, discomfort and reddening, blistering, scabbing, temporary bruising and temporary discoloration of the skin as well as rare side effects such as scaring or permanent discoloration.
I understand treatment involves a series of treatments.
There is a risk of buring from all treatments offered.
There is a risk of scarring.
Short term effects may include reddening, mild burning, temporary bruising or blistering. Hyper-pigmentation (browning) and Hypo-pigmentation (lightening) have also been noted after treatment. These conditions usually resolve within 3-6 months, but permanent color change is a rare risk. Avoiding sun exposure before and after the treatment reduces the risk of color change.
Infection: Although infection following treatment is unusual, bacterial, fungal and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a treatment. This applies to both individuals with a past history of herpes simplex virus infections and individuals with no known history of herpes simplex virus infections in the mouth area. Should any type of skin infection occur, additional treatments or medical antibiotics may be necessary.
Bleeding: Pinpoint bleeding is rare but can occur following treatment procedures. Should bleeding occur, additional treatment may be necessary.
Allergic Reactions: In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations have been reported. Systemic reactions (which are more serious) may result from prescription medicines.
I understand that exposure of my eyes to light could harm my vision. I must keep the eye protection goggles on at all times.
MEDICAL HISTORY
Are you currently under the care of a physician? Yes No
If yes, for what:
Do you have any of the following medical conditions? **(Please check all that apply)** Cancer Diabetes High blood pressure Herpes Arthritis Frequent cold sores HIV/AIDS Keloid scarring Skin disease/Skin lesions Seizure disorder Hepatitis Hormone imbalance Thyroid imbalance Blood clotting abnormalities Do you have any other health problems or medical conditions**?**
Please list: _____

Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced)
 Food Animal Protein Aspirin Lidocaine Hydrocortisone Hydroquinone or skin bleaching agents
 Others**:**

MEDICATIONS

What oral prescription medications are you presently taking? **(Please check all that apply)** Birth control pills
 Hormones

 Others (It is required that you list all of them):

What antibiotics do you use to treat infections?_____

Do you take any medications for heart conditions? _____

Are you on any mood altering or anti-depression medication? _____

What topical medications or creams are you currently using? _____

What herbal supplements do you use regularly? _____

(Please check all that apply)

Are you pregnant or trying to become pregnant? Yes No
Are you breastfeeding? Yes No
Are you using contraception? Yes No

Cryoskin Contradictions- (Please check if any apply to you)

1. __Severe Raynaud's Syndrome, __Severe Allergy to Cold, __Cold-related Illness (Cryoglobulinemia, Paroxysmal Cold Hemoglobinuria, __Cold Agglutinin Disease), ___Progressive Diseases (MS, ALS, __Parkinson's, Neuropathy), __Active Cancer, HIV/AIDS, __Cardiovascular Disease, __Lower Limb Ischemia, __Lymphatic Disorders, __Uncontrolled Diabetes or Diabetes-related complications, __Severe Kidney or Liver Disease, __Pregnancy/Breastfeeding, __Bacterial and viral infections of the skin, __Wound healing disorders, __Circulatory disorders, __Surgery in the past 6 months, __Pacemaker/metal implants, __Active/Severe Eczema, rashes, or dermatitis, __Use of topical antibiotics in desired treatment area, __Silicone/other implants in desired treatment area, ___Mesh inserts in the desired treatment area, Irremovable body piercings in the desired treatment area, __Incision scar(s) in the desired treatment area, __Open or infected wounds, __Impaired skin sensation, __Known sensitivity or allergy to polypropylene glycol, __Hernia in or adjacent to desired treatment area, ___Active implanted device such as pacemaker or defibrillator in or adjacent to desired treatment area

*I have read and acknowledged the contraindications of CryoSkin.

Initial: _____

I certify that I have been given the opportunity to ask any questions I may have.
I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Client/Guardian Signature Date:_____ Date:_____

Client/Guardian Signature Date:_____ Date:_____