CONSENT FORM/CONSULTATION

Fibroblast Plasma Treatment is a procedure that can only be performed by a specifically trained and qualified specialist.. Using approved equipment to shrink the skin using a sterile disposable probe.

Before carrying out the treatment, you are required to complete and sign this consultation record, this giving your absolute consent to treatment. Additionally, you will need to disclose your full medical history, which will determine whether you are a suitable candidate for the proposed treatment. If the specialist does not think you are suitable for the treatment, this will not be carried out.

Your specialist will discuss the procedure in full, including what it will involve, discuss the benefits, explain any risks, the healing process and advise upon any further treatment if / where necessary. You will then be provided with written aftercare information for you to keep and refer to during the subsequent healing process.

Contra-indications will be recorded on this consultation form, which will be used as a reference for future visits.

It is important you clearly mark any areas of this form you wish to have clarified or discuss further. It is ultimately YOUR responsibility to ensure you understand in full the procedure and the expected outcomes before treatment commences.

PLEASE READ CAREFULLY AND SIGN WHERE INDICATED, ONLY when you are happy to proceed. Ensure all points below have been discussed with your specialist. You are signing to state that you understand and accept these terms.

Terms of your treatment:

You have chosen a cosmetic procedure that is not medically necessary.

Fibroblast Plasma lift is an art process,not an exact science and cannot guarantee an exact shrinkage result due to skin elasticity and individual healing process.

You may be required to return for additional treatments before your overall procedure is deemed complete. The payment for any additional work, (if applicable), Additional treatments, cannot be performed until after 4-8 weeks from date of initial treatment. This is in order to allow the initially treated area to heal fully.

Your specialist will use a treatment plan to record the areas you have chosen, Numbing anesthetic will be used on treatment area, as well as pre and post treatment photographs. This information will be held securely in your consultation record.

The skin type of every client is different and the healing process may lead to some discoloration of the skin.If exposed to sun while healing.

After each treatment some swelling or redness may occur. In some cases there may be extreme swelling. Your specialist will give you appropriate advice to help reduce this risk. Throughout the treatment you may experience some discomfort, but your specialist will reassure you throughout and endeavour to make you feel comfortable.

Since the treatment includes small burns to the skin, you may experience the smell of charring. This is perfectly normal.

You must adhere to the specialist's aftercare advice given to you following your treatment. This is very important and will reduce the risk of post procedural infection upon leaving the clinic. You must let the treated area heal properly. Avoid picking, plucking, knocking as this will hinder the healing process and could make the treatment appear uneven thus requiring further work.

TO BE COMPLETED BY THE CLIENT

FULL NAME:
ADDRESS: PC-ZIP CODE:
TELEPHONE: DATE OF BIRTH (DD/MM/YY):
MOBILE: OCCUPATION:
EMAIL: TREATMENT AREA:
PACKAGE: PHOTOGRAPHIC CONSENT: YES NO
PRICE AGREED:

Photographic consent
I consent to photographs being taken BEFORE, DURING, and AFTER my procedure. I agree to these being stored with my case file and used only with my written consent for promotional purposes.

Sign:_____

I understand that my specialist will be in direct contact with me in relation to the plasma pen treatment. This treatment involves the use of a disposable probe. All other equipment is sterilized before use, all surfaces involved in the process are protected and gloves will be worn at all times by the specialist during the treatment.

I hereby consent to receiving a plasma pen treatment. My specialist has explained the terms and conditions of the treatment and I have fully understood these. I hereby give written consent to the specialist who is a fully trained and insured specialist, to carry out the treatment of my choice as requested by me on this consent and treatment agreement.

Print Name: _____ Signature: _____
SPECIALISTS SIGNATURE: _____
DATE: _____

MEDICAL FORM (To be completed by the client)

Full Name:
Date of Birth (dd/mm/yy):
Male or Female (please circle)
Have you received any skin tightening treatment before? YES / NO
If Yes please answer the following questions: How long ago was your treatment?
What procedure did you receive?
At what clinic did you receive the treatment?
Were you happy with the result? YES/NO If no, please explain the reasons why.
Are you over the age of 18?
Are you pregnant?
Are you under the influence of alcohol or drugs?
Are you in good health?
La Peau Plasma Academy Inc CONSULTATION RECORD CLIENT
SIGNATURE:_____SPECIALIST

MEDICAL CONDITIONS Please answer YES or NO to the following questions.

~These details will then be discussed (in confidence) with your specialist. YES NO
~Do you feel fit and well enough to have a Plasma pen lifting procedure today? YES NO
~Do you have any allergies or have you experienced any allergic reactions to medicine or products such as latex gloves, plaster etc? YES NO
~If so please list: Are you currently taking any medication? YES NO
~If so please list: Do you have or are you planning to have any injectables, fillers or chemical peels in the near future? YES NO
~Do you suffer from epilepsy? YES NO
~Do you knowingly suffer from any infectious diseases? YES NO
~Do you suffer from a high or low blood pressure? YES NO
~Do you suffer from diabetes? YES NO
~Do you have any respiratory problems? YES NO
~Do you suffer from, or have any problems with scars healing? YES NO
~Do you suffer from dizziness or fainting attacks? YES NO

~Do you suffer from HIV/AIDS? YES NO
~Do you suffer from heart problems? YES NO
~Do you suffer from Hepatitis? YES NO
~Do you suffer with any Lymphatic problems? YES NO
~Do you suffer from Haemophilia? YES NO
~Do you suffer from skin problems (i.e. Eczema, Psoriasis)? YES NO
~Do you have an allergy to penicillin? YES NO
~Do you suffer from Keloid scarring? YES NO
If you suffer from any of the above it is important that you notify your specialist who can take the necessary precaution to ensure you receive the best treatment to avoid any risks to your health.
La Peau Plasma Academy Inc CONSULTATION RECORD
Notes to discuss;

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 medial history it is my responsibility to inform my specialist.
CLIENT SIGNATURE:_____
SPECIALIST SIGNATURE:_____

TREATMENT PLAN
This part of the consultation record is to be completed by the specialist in order to record important elements of the treatment. This form must be kept with the clients Medical and Consent forms.

PLEASE USE THIS FORM TO RECORD THE TREATMENT OF ONE AREA ONLY.
All other treatments must be recorded on separate treatment plan forms.

Treatment area(s) being completed:
Number of treatments recommended:
For first visit only: Following consultation with your client, what is the agreed treatment and how many visits will it take to achieve?

Treatment Agreement

I, the specialist, 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 treatment. Aftercare advice has been presented to the client.
Specialist signature: _____
Date: _____

Please ask your client to read, understand and sign the following prior to treatment: I, the client, agree with all points listed and discussed, and wish to proceed as recorded. I participated fully in the decision for selected area or areas intended for my treatment. I hereby agree to follow after advice. Client signature: _____
Date: _____

Tolerance Level(1 lowest 10 highest):
Were any other people present?
Notes:

Comments made by the client and/or to the client after the procedure and information relating to further treatments required.

To be completed by the client at the end of the procedure:

My procedure has been completed to my satisfaction and I have been given the opportunity to discuss any immediate concerns with my specialist.

I fully understand my aftercare instructions and have my aftercare advice sheet.
CLIENT SIGNATURE: _____
SPECIALIST SIGNATURE: _____