



CIRCADIA  
by Dr. Pugliese

Advanced Professional Skincare

## INFORMED CONSENT FOR OXYGEN RX AND ENZYMES TREATMENT

Initial on line

I, \_\_\_\_\_, give permission to my skin care professional,  
\_\_\_\_\_, to perform the Circadia treatment:

☐ Oxygen Rx Treatment      ☐ Cocoa Enzyme      ☐ Raspberry Enzyme      ☐ Zymase Enzyme

1. I agree to complete a Confidential Skin Health Questionnaire. I agree to complete and be truthful about my physical conditions, pregnancy, medications that I may be taking, and my current skin care regimen. I am also aware that my lifestyle, which if it includes smoking, outdoor exposure, tanning beds, excessive alcohol consumption and/or recreational use of controlled substances, will effect and diminish the effectiveness and result of the treatment.
2. I have disclosed to my skin care professional any surgical procedures, laser treatments, or facial procedures that I have had or intend on having in the future.
3. I am not presently pregnant or lactating
4. I have not had any recent chemotherapy or radiation treatments
5. I have not recently waxed or used a depilatory (such as Nair) on the area being treated today. I do not have a history of keloid scarring, diabetes, any autoimmune disease, active herpes blisters or cold sores.
6. I understand that I should not have a treatment if I intend to be in the sun or use a tanning bed and will refrain from excessive sun exposure and the use of a tanning bed while I am undergoing treatment.
7. I have disclosed to my skin care professional any treatments of any kind that I have received within 14 days of this treatment whether the treatment was performed at this location or any other location.
8. I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complication, I will immediately contact the skin care professional who performed the treatment.

9. I understand that the following conditions preclude me from having this treatment at this time and verify that none of these conditions apply to me at this time.

- \_\_\_\_\_ Allergic to citric fruits (oranges, limes, grapefruit, lemons)
- \_\_\_\_\_ Allergic to cocoa, chocolate, and/or raspberry
- \_\_\_\_\_ Allergic to pineapple and/or papaya
- \_\_\_\_\_ History of being "highly allergic" to anything
- \_\_\_\_\_ Pregnant or lactating
- \_\_\_\_\_ Current use of antibiotics (topical or systemic)
- \_\_\_\_\_ Use of Accutane® within the past 12-months
- \_\_\_\_\_ Laser resurfacing surgery within the last 12-weeks
- \_\_\_\_\_ Using glycolic acid products
- \_\_\_\_\_ Use of Retin-A®, Renova®, retinoids (Vitamin A) in the last 4-weeks
- \_\_\_\_\_ Broken Skin on areas to be treated
- \_\_\_\_\_ Visible inflammation or inflammatory lesions
- \_\_\_\_\_ Recent peels within four weeks
- \_\_\_\_\_ Herpes virus (cold sores) on mouth
- \_\_\_\_\_ Laser Hair Removal within 6 weeks
- \_\_\_\_\_ Currently undergoing chemotherapy or radiation treatments

10. I understand the cost of the treatment and the fee structure has been explained to me.

11. My expectations are realistic and I understand that the results are not guaranteed and that for maximum results, more than one application may be necessary. The rate of improvement depends on my skin type, condition, my age, degree of sun damage, or pigmentation levels.

12. I understand that my practitioner will recommend home care products to work in tandem with the in-clinic treatment. I am willing to follow recommendations by my skin care professional for home care, including a sunscreen.

13. I consent to the taking of photographs to monitor treatment effect and results if desired by my skin care professional.

### **INFORMED CONSENT**

In the event of any questions or concerns, I will consult my skin care professional immediately. I understand the potential risks and complications and I have chosen to proceed with the treatment after careful consideration of both known and unknown risks, complications, and limitations. I will hold the skin care professional and staff harmless from any liability that may result from this treatment.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Skin Care Professional \_\_\_\_\_ Date \_\_\_\_\_