

## Laser and Lipstick RADIO FREQUENCY Client Consent Form

Radio Frequency (RF) treatment is for treatment of wrinkles and skin tightening, by delivering a bipolar RF to the skin. This causes immediate contraction of the collagen fibers followed by a tightening over time.

By completing this client profile, you will assist us in evaluating your condition. The information you provide will be used to determine what factors may be affecting you so that we may recommend the proper care.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Birth date: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Please list all medications that you take regularly. Include hormones, vitamins, etc.: \_\_\_\_\_

Please circle any health conditions, which you have had, or are now experiencing:

Cancer      Pregnancy      Lupus      Thrombosis      Phlebitis      Hemophilia      HIV      Hepatitis  
Recent Illness      Light/Photo Sensitivity      Heart Problems      Pacemaker      Multiple Sclerosis  
Metal Implants/Screws      Hormonal Disorders      Hypoglycemia      Thyroid Disorders      Diabetes  
Lack of Normal Skin Sensation      Recent Surgery

Allergies: \_\_\_\_\_

Have you ever undergone plastic surgery? \_\_\_\_\_ If yes, when? \_\_\_\_\_

Where on your body? \_\_\_\_\_

Have you had any anti-wrinkle fillers in area of concern? \_\_\_\_\_

Do you smoke? How many per day? \_\_\_\_\_

What specific improvements do you wish to see? \_\_\_\_\_

In what time frame do you expect to reach your goals? \_\_\_\_\_

What skin care do you use AM? \_\_\_\_\_

What skin care do you use PM? \_\_\_\_\_

I understand that RF treatments cannot prevent future skin aging. Multiple treatments are required and there is no guarantee that the wrinkles or sagging skin will be completely addressed. Results are individual. While it is expected to have a 40% to 50% improvement in the treated area after a completed series of weekly treatments, it is impossible to guarantee results. Some people exceed our expectations and some people respond below expectations. Weekly treatments present the best outcome in most individuals.

I agree pre/post treatment photographs will be obtained, for the sole purpose of future reference to compare my results. Photos will be kept confidential and not will be used for other purposes without permission.

I understand that there is a possibility of rare side effects such a scarring and permanent discolouration as well as short term effects such as reddening, swelling, mild burning, blistering, burns, scabbing or temporary discolouration of the skin. These effects have all been fully explained to me and my questions have been answered. I accept the risks and complications of the procedure.

Client Full Printed Name \_\_\_\_\_ Date \_\_\_\_\_

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

Witness Full Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_