DERMAWAVE INFORMED CONSENT

ACHIEVE Beautiful SKIN MEDI-SPA VIERA

CLIENT/PATIENT CONSENT TO TREATMENT:

My signature acknowledges that I have read the following and agree to receive the treatments or series of treatments listed below.

I, _____, consent to and authorize:
PLEASE PRINT NAME

Jeanne L. Whitman, CCE, CME, to perform ultrasound and electrotherapy (DermaWave) treatments and other services.

Reason for your visit: (Please describe your specific skin problem) _____

_____

_____

_____

Areas to be treated: _____

Number of estimated treatments: _____

1} _____ The nature and purpose of the treatment has been explained to me, and any questions I have regarding this procedure have been explained to my satisfaction.

2} _____ I understand that with any treatment certain risks are involved and that any complications or side effects from known or unknown causes could occur. I freely assume these risks.

3} _____ I do not wear a cardiac pacemaker.

4} _____ I am not pregnant.

5} _____ I do not have hemorrhagic disease nor am I taking blood thinner medication.

6} _____ I do not have vascular disease or any history of stroke or thrombosis.

7} _____ I have no know diagnoses of cancer

8} _____ I have not fractured any bones in the last six months.

9} _____ Yes/No Do you have any cheek or chin implants?

10} _____ Yes/No Do you have metal fillings in your teeth?

11} _____ Yes/No Are you wearing braces?

12} _____ Yes/No Have you had any Botox injections in the last 7 days?

13} _____ Yes/No Have you had any Collagen or filler injections in the last 7 days?

14} _____ Yes/No Are you taking any medications currently?

15} _____ Yes/No Have you had any adverse reactions to any skin care products?

16} _____ Yes/No Are you Diabetic?

17} _____ I also understand that the DermaWave treatment may be delivered in combination with other modalities including microdermabrasion, and that specialized topical may be used to address specific skin conditions. Adherence to the regime provided to me in the use of these topicals is important to the success of the DermaWave treatment. Any questions relative to the use of these topicals should be addressed to your skin care specialist.

18} _____ Possible side effects include, but are not limited to, mild to extreme redness, bruising, local swelling, stinging, tenderness, dry skin, flaking, lightening or darkening of the skin, infections, pimples, bumpy appearance, and cold sores. Most side effects are temporary and generally subside within 72 hours.

19} _____ If I am prone to Herpetic outbreaks, I have been advised to see my physician about a prescription for Acyclovir or Zovirax.

20} _____ *(For exfoliation treatments)* I have been advised to discontinue all AHA's Glycolics, Retin A, Renovo, or any exfoliation products for up to 72 hours post-procedure. I understand that I must use hydration and soothing antioxidants for healing, and ice for swelling and inflammation reduction.

21} _____ Also, I understand there should be no sun exposure for at least 72 hours and SPF 30 should be used at all times during the treatments duration.

22} _____ I have been advised to avoid any and all aesthetic injectables to the face (i.e. collagen) for up to 10-14 days before and to avoid Botox injections for up to 7 days before any microdermabrasion treatment and agree to these restrictions.

23} _____ I agree to adhere to all safety precautions and home skin care programs as recommended by my skin care specialist.

24} _____ I am over 18 years of age or I have parental consent co-signed below.

25} _____ I will call to inform my skin care specialist of any complications or concerns I may have as soon as they occur.

Client Signature _____ **Date** _____

Parental Signature _____

Skin Care Specialist _____

JEANNE L. WHITMAN CCE, CME