HYDRAFACIAL™ TREATMENT CONSENT FORM

HydraFacial is the only hydradermabrasion procedure that combines cleansing, exfoliation, extraction, hydration and antioxidant protection simultaneously, resulting in clearer, more beautiful skin with little-to-no downtime.

The treatment is soothing, moisturizing, non-invasive and generally non-irritating. As with most procedures, visible results from HydraFacial will vary from person to person.

What to expect:

- Your skin may experience temporary irritation, tightness, or redness. These are all normal reactions that typically resolve within 72 hours depending on skin sensitivity.
- You may experience tingling and stinging in the treatment area. These sensations generally subside within a few hours.
- Client experiences may vary. Some clients may experience a delayed onset of these symptoms.
- You will likely see results immediately after treatment and your skin may feel smooth and hydrated for one to four weeks with appropriate home care to maintain treatment results.
- The skin is more susceptible to sunburn/sun damage. Avoid excessive sun exposure and use a minimum of SPF 40 sunscreen.

Do you have any of the following?*

- Active acne or infection ______ ☐Yes ☐No
- Open lesion or cold sore ______ ☐Yes ☐No
- An active infection in the treatment area ______ ☐Yes ☐No
- Active sunburn ______ ☐Yes ☐No
- Skin conditions such as eczema, dermatitis, or rashes ______ ☐Yes ☐No
- An autoimmune disease such as lupus ______ ☐Yes ☐No
- A viral concern such as HIV or hepatitis ______ ☐Yes ☐No
- Anticoagulants Therapy ______ ☐Yes ☐No
- Melanoma or lesions suspected of malignancy ______ ☐Yes ☐No
- Pregnancy or lactation ______ ☐Yes ☐No
- Neurological disorders such as epilepsy (LED Lights) ______ ☐Yes ☐No
- Infection in the urinary system i.e. kidneys, bladder and urethra (Lymphatic drainage) ______ ☐Yes ☐No
- Crohn’s Disease (Lymphatic drainage) ______ ☐Yes ☐No
- Hyperthyroidism (Lymphatic drainage) ______ ☐Yes ☐No
- Deep Venous Thrombosis (Lymphatic drainage) ______ ☐Yes ☐No
- Lymphedema (Lymphatic drainage) ______ ☐Yes ☐No

*Saying yes does not preclude you from receiving treatments.

Have you recently?

- Used Accutane, topical medications or antibiotics ______ ☐Yes ☐No
- Had aesthetic fillers, injectables or laser treatments ______ ☐Yes ☐No

I acknowledge the following:

- I will avoid the use of aggressive exfoliation, waxing, and products containing glycolic acids or retinols that are not part of the recommended take-home regimen in the treated areas for minimum 2 weeks pre- and post-treatment.
- Photos may be taken before, during and after the HydraFacial treatment. Photos will only be used with my written approval for education, promotion or advertising purposes.
- The information provided has been explained to me and all my questions have been answered to my satisfaction. I have read the above information, and I give my consent to have the HydraFacial treatment by the staff at [Insert].
- By signing below, I acknowledge that I have read the above information and give my consent to be treated with the HydraFacial System.
- This consent form is valid for all future HydraFacial treatments. I will alert the staff If there are any future changes to my medical history.

Print name: ________________________ Signature: ________________________ Date:_______________

MICRONEEDLING PRE & POST CARE INSTRUCTIONS

Pre-Treatment Instructions:

- Avoid sun exposure or tanning bed at least 24 hours prior to treatment and during treatment process.
- Avoid Retinol products for 24 hours.
- Do not exercise the day before or for 48 hours after the treatment.
- Avoid medications such as: Aleve, Advil, cold remedies, Vitamin E or aspirin 5 days prior to treatment
- Avoid Retin-A, chemical peels, filler injections, or Botox 2 weeks prior to treatment
- Notify medical aesthetician if you get or have ever had cold sores. You will require an antiviral prescription to avoid any breakout after treatments.
- If you have open cuts, wounds, abrasions, active acne or cold sore breakout, we cannot perform the procedure.

Post Treatment Instructions:

- What to expect:
  - **Day 1**: Skin will be flushed, and may experience erythema after treatment, depending on the intensity of the treatment. Pinpoint bleeding may occur.
  - **Day 2**: A red or pink hue persists like moderate sunburn. Swelling and slight bruising may be more noticeable on the second day. Minor scratches may be visible. Apply moisturizer as needed.
  - **Day 3**: Skin can be pink or normal color. Swelling subsides. The skin can feel dry or feel tight. A slight outbreak of acne or milia (tiny white bumps) is possible. Light peeling usually occurs in about three days and will be replaced with brand new skin.

- If neck or decollete are treated, the redness might last a little longer.
- Avoid exfoliants for 72 hours. (Scrubs, acids, retinols, ect)
- May apply 1% Hydrocortisone cream or Benadryl spray or gel on treated areas to reduce itching or redness after 48 hours.
- You may take Arnica Montana up to 7 days after each treatment to decrease brusing and inflammation.
- No excessive exercise for 48 hours after treatment
- Avoid saunas, steam rooms, hot baths or showers until redness is gone.
- Continue to avoid sun exposure to the treatment areas and apply a broad spectrum sunscreen with SPF minimum of 30. Apply it at least 30 minutes prior to sun exposure and repeat after every two hours of sun exposure
- After 2-3 days patients can return to regular skin care products or as soon as it is comfortable to do so..
- Avoid waxing, facials, botox, injectable fillers or any other skin care treatment two weeks after treatment.
- New cell regeneration requires at least 6-8 8oz. glasses of water a day (if you already drink that -- increase by 2 glasses)
- If skin becomes painful, swollen, red or inflamed, please notify us immediately at (314)469-1222 as this may represent an infection or allergic reaction that may require treatment.

SKINPEN PATIENT CONSENT FORM

Description of the Procedure: Microneedling treatment allows for controlled induction of the skin' self repair mechanism by creating micro-'injuries' in the skin, which triggers new collagen synthesis, yet does not pose the risk of permanent scarring. The result is a smoother, firmer and younger-looking skin. Microneedling procedures are performed in a safe and precise manner with the use of the sterile needle head. The procedure is normally completed within 30-60 minutes, depending on the required treatment and anatomical site.

Side Effects: Dryness, rough skin, redness, itching, peeling, discomfort, tenderness and burning; these conditions resolve over time without any further complications. Pigment changes, including lighter or darker skin in the treatment area, that will resolve over time. Possible reactivation of herpes simplex virus.

Contraindications: Microneedling treatment should not be used on patients who: 1. Have active skin cancer in treatment areas. 2. Have open wounds, sores, or irritated skin in treatment areas. 3. Have allergy to stainless steel or anestheics. 4. Have a hemorrhagic (bleeding) disorder or hemostatic (bleeding) dysfunction. 5. Are pregnant or nursing. 6. Are currently taking drugs with isotretinol (such as accutane).

Precautions and Warnings: Microneedling treatment has not been evaluated in the following patient populations, as such, precautions should be taken when determining whether to treat: scars and stretch marks less than one year old; women who are pregnant or nursing; keloid scars; patients with history of eczema, psoriasis or other chronic conditions; patients with history or actinic (solar) keratosis; patients with history of herpes simplex infections; diabetics or patients with wound-healing deficiencies; patients on immunosuppressive therapy; and skin with presence of raised moles or warts on targeted area.

Patient Consent: I understand that results will vary among individuals. I understand that although I may see a change after my first treatment, I may require a series of sessions to obtain my desired outcome.

The procedure and side effect have been explained to me including alternative methods, as have the advantages and disadvantages.

I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the success or other result of the treatment. I am aware that microneedling treatment is not permanent as natural degradation will occur over time.

I state that I have read (or it has been read to me) and I understand this consent and I understand the information contained in it. I have had the opportunity to ask any questions about the treatment including risks or alternatives and acknowledge that all my questions about the procedure have been answered in a satisfactory manner.

This consent form is valid until all part or part is revoked by me in writing.
Print Name: ____________________
Signature: ____________________
Date: ____________________
Practice Name: ____________________

Informed Consent for Dermaplaning

I____give my consent for the following procedure:

Dermaplaning to be performed by StudioBranca SalonSpa.

I understand there are contraindications to this treatment, including but not limited to diabetes, cancer, active acne, bleeding disorders and the inability for blood to coagulate following injury. Certain medications including blood thinners, higher dosages of Aspirin, and Accutane are contraindicated for this treatment due to the possibility of delayed clotting from a nick or cut.

I certify that I am not taking any of the above medications or experiencing any of the above conditions.

I understand this treatment involves the use of a surgical blade to remove dead skin cells and villous hair. As with the use of any sharp instrument there is the possibility of nicks or cuts. While every precaution is taken, I understand the risks and consent to receive treatment today.

Name ________________________________Signature____

Date_________________________________Witness____

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name______________________________________ Today's Date________________

Date of Birth_________Age_________Occupation_____________________________

Home Address______________________ City___________________ State___Zip Code_____

Home Phone (___)_______________________Work Phone (____)______________________

Emergency Contact Name and Phone____

How were you referred to us? ____

Do you regularly sun bathe or use tanning salons?____________How often?________________

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 ☐Any active infection

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? ❑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? ❑ RetinA , ❑Others (Please list):

____

What herbal supplements do you use regularly?______________________________

HISTORY

For our female clients:

Are you pregnant or trying to become pregnant? ❑Yes ❑No Are you breastfeeding? ❑Yes ❑No

Are you using contraception? ❑Yes ❑No

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.

Signature____ Date:______________