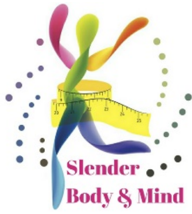

RADIO FREQUENCY for Face or BODY

TREATMENT CONSENT FORM

Name: ____ Date: ________________________
DOB: __________ Phone: ___________________ Email: ____

Area of treatment: *(Circle one)* Face - Body

Medical history: (please mark any that apply to you)

_____ Pregnancy or nursing (current only).
_____ Pacemaker or internal defibrillator, implanted neuro-stimulators or another internal electric device.
_____ Current or history of, cancer - especially skin cancer, or pre-malignant moles in treatment area.
_____ Diabetes and Impaired immune system due to immunosuppressive diseases such as AIDS and HIV.
_____ Immune suppressive medications.
_____ Medications such as blood thinners.
_____ Severe concurrent conditions such as cardiac disorders or epilepsy.
_____ Condition which could be adversely affected by heat.
_____ A history of diseases stimulated by heat, such as recurrent Herpes Simplex in the treatment area.

_____ Chemical sensitivities such as reactions to cosmetic products or perfumes. If known, please list specific offending ingredients:
_______________, ___________________,
__________________ .
_____ History of skin disorders such as keloid scarring, abnormal wound healing, as well as very dry and fragile skin.
_____ Any surgical, invasive, ablative procedure in the treatment area before complete healing.
_____ Any medical condition that might impair skin healing

_____ Areas of sensory impairment such as in cases of nerve lesions and neuropathies.

_____ Any active condition in the treatment area, such as sores, psoriasis, dermatitis, eczema and rash as well as excessively/freshly tanned skin.

If getting the Face treated:
_____ Dental implants, braces, caps, metal fillings (amalgams, gold)
_____ Botox or filler in treatment area.
_____ Active weeping acne.
_____ Continuous use of Retin A, retinol or any other Vitamin A derivatives.
_____ Herpes (active).

If getting the BODY treated:
_____ Heavy menses/bleeding.
_____ Metal implants or other implants in the treatment area- i.e. IUD, screws, plates.
_____ Varicose veins in the treatment area.

If you answered YES to any of the above, please explain: ____
____

Please list any medications you are currently taking:
____
____

Disqualifying Conditions for Multipolar Radio Frequency Treatments

Check off in not applicable

NO:

_____ Implants: heart pace-maker, braces, cochlear implants
_____ Coagulation dysfunction or bleeding disorders
_____ Organ transplants
_____ Pregnancy
_____Acute hernia, discopathy, spondylolysis
_____ Lactation
_____Migraines or Epilepsy
_____ Tuberculosis
_____Malignant Tumors
_____ Not feeling thermal changes
_____Acute infections or inflammations

_____ A burn or care after such a burn
_____ Active cancer
_____ Botox or filler in treatment area
_____ Severe cardiovascular disease, circulation
_____ Accutane and retinol
_____ Suppuration of soft tissues
_____ Severe active arthritis
_____ Active gout Kidney stones
_____ Any active condition in the treatment area, such as troubles (thrombus arterial sclerosis, etc.) Herpes, sores, psoriasis, dermatitis, eczema and rash

Please initial:

_____ I understand that taking the treatment course is my choice and that I am free to withdraw at any time, without giving any reason.

_____ I was told about the possible side effects of the treatment including: skin redness (erythema) and warmth.

_____ Although these effects are rare and expected to be temporary, any adverse reaction should be reported immediately.

_____ I understand that not everyone is a candidate for this treatment and results may vary.

_____ I confirm that I have read and understood the above information and will undergo the treatment out of my own free will.

_____ I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of a cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

_____ I believe I have adequate knowledge upon which to base an informed consent.

_____ FINANCIAL: I understand that all payments are due at time of service. To receive package prices, payment must be made for the entire package prior to service.

_____ CANCELLATION/Rescheduling Policy: ***Please be aware that all cancellations require a minimum of 24hrs notice. Failure to do so will result in that treatment being deducted from your course without a refund.*** It is important to be aware that this may have a negative effect on your overall results. Any changes to the initial treatment dates will be subject to availability.

_____ Due to the demand for treatments, we schedule all appointments following the initial consultation.

_____ I authorize before, during and after the procedure(s) the taking of photographs to be part of my patient profile.

_____ I understand that it is my personal responsibility to inform the clinician of any changes to my medical history during the course of Radio Frequency treatment sessions and I confirm that should this occur I shall advise the clinician of any changes I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

I ___________________________________ confirm that all information provided above is correct to the best of my knowledge.

Client Signature: ____ Date: ________________________

Licensed Esthetician Signature: ____ Date: _______________________

 Client Name: ____ Client Initials ___________