The Skin Inn IPL Photorejuvenation with Regenerative Collagen Therapy Agreement Form

Client Name: ____ (please print)

To the Patient: Being fully informed about your condition and treatment will help you to make the decision or whether or not to undergo an IPL Photorejuvenation treatment. This disclosure is not meant to alarm you; it is simply an effort to better inform you so that you may give or withhold your consent for this treatment.

Please **initial** below:

____ I understand that: Serious complications are rare but possible. Common side effects include temporary redness and mild "sunburn" like effects that may last a few hours to 3-4 days or longer.

____ Pigment changes (light or dark spots on the skin) lasting 1-6 months or longer may occur. In addition, freckles located in the areas of treatment may lighten and/or temporarily or permanently disappear in treatment areas.

____ Other potential risks include blistering, crusting, itching, pain, bruising, skin whitening, bumps, infections, scabbing, swelling, and failure to achieve the desired results. Intense light can cause eye injury and protective eyewear must be worn during treatment.

____ I understand that sun exposure or use of tanning lamps or self-tanning creams and not adhering to the post-care instructions provided to me may increase my chance of complications.

____ I understand the importance of having an accurate diagnosis by a physician of brown spots prior to treatment, as treatment of an undiagnosed skin cancer may delay proper medical care.

____ I consent to photographs being taken to evaluate treatment effectiveness, for medical education, training, professional publications, or sales purposes. No photographs revealing my identity will be used without my written consent.

____ **I understand that the practice of laser/IPL treatments is not an exact science, and no guarantees can be or have been made concerning expected results.**

____ **I understand that multiple treatments are required to produce the desired results.**

Before and after treatment instructions have been discussed with me. I have read and understand the additional exclusionary criteria. The procedure as well as, potential benefits, and risks have been explained to my satisfaction. I have had all my questions answered. I freely consent to the proposed treatment.

I certify that I have read and understood this treatment agreement and that all the blanks were filled prior to my signature.

____ ___________________________________

Client Signature **Date**

Post Treatment Instructions for IPL Photorejuvenation with Regenerative Collagen Therapy

Client Name: ____ (please print)

Please observe the following after IPL Photorejuvenation

- A mild sunburn-like sensation is expected. This usually lasts 2-24 hours and can persist up to 72 hours.
- Mild swelling and/or redness may accompany this, it usually resolves in 2-3 days.
- Apply ice or cold packs to the treatment area for 10-15 minutes every hour as needed
- An oral pain reliever, such as acetaminophen may be taken to reduce discomfort. Use according to the manufacturer's instructions.
- In some cases, prolonged redness or blistering may occur. An antibiotic ointment may be applied to the affected areas twice daily until healed (follow manufacturer's instructions). Do not pick or scratch the blister!
- Bathe or shower as usual. Treated areas may be temperature sensitive. Cool shower or baths will offer relief
- Avoid aggressive scrubbing and use of exfoliants, scrub brushes, and loofah sponges until the treatment area has returned to its pre-treated condition.
- Until redness has completely resolved, avoid all of the following:
  - Swimming, especially in pools with chemicals such as chlorine.
  - Saunas
  - Activities that cause excessive perspiration and/or increase circulation.
  - Sun exposure to treated areas. Apply an SPF 30 or greater sunscreen to prevent development of new pigmented lesions.

If you have any questions or concerns, please do not hesitate to contact our office. I have read and understand the post treatment instructions. By signing below, you understand and are agreeing to follow these instructions, have received a copy of the above and are agreeing that all your questions have been answered to your satisfaction.

____ ___________________________________

Client Signature **Date**

** Take a picture of the Post Treatment instructions for your own records **

Score	0	1	2	3	4
What is the color of your eyes?	Light blue, Gray	Green	Blue	Brown	Dark brown
What is your natural hair color?	Red	Blond	Chestnut, Dark blond	Dark brown	Black
What is the color of your skin (non-exposed areas)?	White	Very pale	Pale with a beige tint	Light brown	Dark brown
Do you have many freckles on unexposed skin areas?	Many	Several	Few	Incidental	None
	←—–-- TOTAL SCORE FOR GENETIC DISPOSITION				

Score	0	1	2	3	4
What happens when you stay in the sunlight too long without sunblock?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had a problem
To what degree do you brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark very quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	←—–-- TOTAL SCORE FOR REACTION TO SUN EXPOSURE				

Score	0	1	2	3	4
When did you last expose your body to the sun or artificially tan?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
Did you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always
	← TOTAL SCORE FOR TANNING HABITS				

TOTAL SKIN TYPE SCORE:

I attest that the above information is true and understand that my provider relies on this information to provide safe and effective treatment.

____

Client Signature

____

Date

Skin Type Score	Fitzpatrick Skin Type
0-7	I
8-16	II
17-25	III
25-30	IV
30-40	V

The Skin Inn Confidential Skin Health Questionnaire

Client Information

Date ________________

Name ____

Address____

City/State/Zip _____________________________________

Phone Number _____________________________________

E-mail ____

Date of Birth _______________________ Age _____________

Occupation ____

Referred by ____

Have you been treated for: (please circle)

Acne Skin Disease Cancer Diabetes

Currently under the treatment of Accutane? _____

Do you smoke? _____

List all medications you are currently taking

that make your skin sensitive or light sensitive: ______

____

Pregnant? _____ Trying to get pregnant? ______

Prone to cold sores?______

Used Retinols/Retin A in the last 72 hours? ______

Allergic to aspirin/shellfish? ______

Allergic to glues/adhesives? ______

Personal Information

Ounces of water you drink daily? _______

Your last sunburn? _______

When you go out in the sun, do you (circle one):

Always burn Usually burn Sometimes burn Rarely burn Very rarely burn Never burn

Do you use a daily SPF? ____

Have you ever been under the treatment plan of a:

Dermatologist ___ Plastic surgeon ____ Esthetician ____

Have you had cosmetic injectables within the last 2 weeks? _________

What skin line are you currently using? ______________________________________

In order of importance, please rank 1 (most important) to 5 (least important) improvement in the next 30 days:

___ Reduction of fine lines ___ Reduction of brown spots/sun damage ___ Reduction of redness

___ Reduction of oil/acne ___ Acne scars diminished

Consent

_____ By initialing here, I understand that The Skin Inn values your business and ask that you respect the spa's scheduling policies. Should you need to cancel or reschedule, please notify us at least 24 hours in advance.

_____ By initialing here, I hereby give my consent and authorization and voluntarily release The Skin Inn from any claims, implied or stated, that I have or may have in the future with this treatment or any others. This includes Skin Care Services, Speciality Services, Lash & Brow Services, and any Add-on Treatments, regardless of result. I am stating that precautions of this treatment or any others have been explained to me in detail and that I fully understand.

_____ By initialing here, I understand that if I have any questions, concerns or comments regarding my skin or the treatment(s) that I receive, I should contact The Skin Inn at **772-546-1222**

Signature: ____ **Date:** ______________

Physician Signature & Approval for Treatment

I certify that I have reviewed this client's confidential skin health questionnaire and consent form. As Supervising Physician, I approve this client for IPL Photorejuvenation & Collagen Regenerative Therapy according to the protocols filed with the state.

Supervising Physician's Signature: ____

Date: ________________