Florida Medspas
Where aging is optional

Address 1 2445 Country Place Blvd. Suite 103, New Port Richey, FL 34655.
Address 2 6928 W. Linebaugh Ave. Suit 102, Tampa, FL 33625
Phone (813) 749-7143
Fax (813) 264-9262
Website www.floridamedspas.com

Laser Hair Removal Consent

Name (Last):_____ (First):_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Homephone:_____ Cellphone: _____ Email Address:_____

Area(s) to be treated:_____ No of treatments:_____

Groupon #: _____ Pd: $ _____ ◯ Cash ◯ Check CC/last four digits:_____

Please indicate YES or NO for each of the following:

Histamine [hives)]	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No
Herpes/ Cold Sores	◯ Yes	◯ No
Skin Cancer	◯ Yes	◯ No
Keloids	◯ Yes	◯ No
Smoking	◯ Yes	◯ No
History of Acne	◯ Yes	◯ No
Any Blood Disease	◯ Yes	◯ No
Depression medication or mood altering drugs	◯ Yes	◯ No
Allergies	◯ Yes	◯ No
Present Illnesses	◯ Yes	◯ No

Present Medications: ☐ Accutane ☐ Aspirin ☐ Antibiotics
☐ Cortisone ☐ Photosensitive such as Hormones
☐ St. Johns Worth ☐ Oral Contraceptives
☐ Others:

Pregnant? ◯ Yes ◯ No

Skin: ◯ Light ◯ Medium ◯ Tan ◯ Olive ◯ Brown ◯ Dark brown

Tanning/Sun Exposure: ◯ Daily ◯ Weekly ◯ Monthly ◯ Year

Previous Treatments: ☐ Tweezing ☐ Waxing ☐ Shaving
☐ Bleaching ☐ Electrolysis ☐ Laser

INT_____I agree that the information listed above has been reviewed and presented with my clear understanding of what this procedure involves. I, the undersigned declare that I have answered all the above questions to the best of my ability and knowledge. I will not hold any CCE, CME, Physician or any member/ staff responsible for any errors or omissions that I may have made in the completion of this form. With full and clear understanding, by signing below I release the technician from liability associated with these procedures.

INT_____Patient Consent: The purpose of this procedure is to diminish or remove unwanted hair. The procedure requires more than one treatment and may produce permanent hair removal. In order to ensure maximum results, it is necessary to follow the recommended treatment schedule. The total number of treatments will vary between individuals. The treated hair should exfoliate or push out in approximately 2-3 weeks. On rare occasion, there are patients that do not respond to treatments. I understand the nature, goals, limitation and possible complications of this procedure and have discussed alternative forms of treatment. I have had the opportunity to ask questions about the procedure, as well as any limitations, complications and/or side effects.

It is the client's full responsibility to keep track of his/her scheduled appointments. If client fails to notify of appointment cancellation at least 24 hours in advance, the no-show will be counted as used treatment of the client's package deal.

I have read, agree to and understand the following:

INT_____The goal of any aesthetic laser treatment, as in any cosmetic procedure, is improvement, not perfection and results may not be perfect due to any genetic, hormonal, nutritional, or topical applications interference or an impact of unpredictable reactions.

INT_____However slight, there is a risk of scarring. It is important to follow all post treatment instructions carefully, compliance is crucial for healing and prevention of scarring.

INT_____Short term effects may include discomfort at treatment site, redness, swelling, mild burning, and temporary bruising or blistering. (This may last anywhere from few days to a few weeks). Hyper-pigmentation (darkening) and Hypo-pigmentation (lightening) have also been noted after treatment. These conditions usually resolve within 1-4 months, but permanent color change is a rare risk. Avoiding sun exposure before and after treatment reduces the risk of color change.

INT_____This applies to both individuals with a past history of herpes simplex virus infections and individuals with no known history of herpes simplex virus infections.

Bacterial, fungal and viral infections can occur. Herpes simplex (viral infections) around the mouth can occur following a treatment. Should any type of skin infection occur, antibiotics are necessary.

INT_____Allergic Reactions: In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations have been reported. Systemic reactions (which are more serious) may result from prescription medicines.

INT_____If laser treatment is not effective due to weak pigment, no pigment, gray/white/blonde/red hair, and/or interference of medications or health conditions:

INT_____Occasionally, unforeseen mechanical problems occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to

your arrival to the office. Please be understanding if we cause you any inconvenience.

INT_____Do not accept advice from anyone not directly responsible for your post care. Suggestions from friends may be sincere, but are often not helpful or even innocently harmful. Follow all pre and post care instructions provided by your provider.

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Liability Release Form and Refund Policy

INT_____**Company Cancellation Policy:** For any credit card payments - a 10% surcharge and merchant fee will be deducted in case of any refund after original transaction.

INT_____**PACKAGE REFUND POLICY:** I fully understand that by purchasing a package deal I am receiving a prepaid, multiple-treatment discount. Therefore, if at any time during the treatments I decide to discontinue and/or cancel my contract, the price of the full package I prepaid will be prorated for the amount of treatments I received up until the cancellation date (based on the cost of one full menu price treatment). I fully understand there will be no reason or excuse to get a full refund for any package deal at any given time if I have already received treatment(s). I have taken into consideration and understand that we made the commitment for the treatment, consultation, and the doctor/PA, ARNP, CCE, CME, and/or instructor's valued time.

Acknowledgment

I have read and understand all of the above. I have asked any and all questions that I have regarding the procedure of laser hair removal, pre-treatment and post-treatment instructions. I understand completely and will take full responsibility for post-treatment care. All of the treatment fees have been discussed with me and I understand them completely. No cancellations of payment, refunds, or discounts of any kind will be applied/given to the customer 48 hours after signing and first full treatment is completed.

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release all related staff from all liabilities associated with the above-indicated procedure(s). By signing this form, I am giving Westchase MedSpa permission to treat me and I understand all symptoms and side effects that may occur during or after treatments, thereby releasing Westchase MedSpa of all liability regarding these issues.

Should you have any concerns or questions, please do not hesitate to call our office. (813) 749-7143

Note: BY SIGNING THIS AGREEMENT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL BINDING ARBITRATION RATHER THAN BY A JURY OR A COURT TRIAL. CERTAIN PORTIONS OF THE ELECTIVE MEDICAL PROCEDURES THAT THIS PROVIDER PERFORMS MAY NOT BE COVERED BY THE PROVIDERS' OR FACILITIE'S LIABILITY INSURANCE POLICY AND IT IS YOUR RESPONSIBILITY TO INQUIRE OF THE PROVIDER CONCERNING THOSE PROCEDURES YOU HAVE REQUESTED. I acknowledge being given a copy of this Agreement at the time it was signed.

Print Name:_____ Signature: _____ Date:_____

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Client Treatment Consent and Release

I acknowledge that beauty treatments, the practice of skin care, and the practice of massage, including, but not limited to, microablation, microdermabrasion, waxing, electrolysis, facial toning, permanent cosmetics, body treatments, ionization, laser treatments, tattoo removal, vein treatments, brown spot removal, BOTOX, Collagen, Dermal Fillers, Sclerotherapy, Mesotherapy, Dermaplaning, and various other beauty procedures is not an exact science and no specific guaranties can or have been made concerning the outcome. I understand that some clients experience more change and improvement than others. In virtually all cases, multiple treatments are required inorder to realize a difference.

I also understand and agree to assume the following risks and hazards which may occur in connection with any particular treatment including but not limited to: unsatisfactory results, soreness, poor healing, discomfort, redness, blistering, nerve damage, scarring, infection, and change in skin pigmentation, allergic reaction, muscle damage, and increased hair growth. I understand that even though precautions may be taken in my treatment, not all risks can be known in advance.

Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. Therefore, in consideration for any treatment received, I agree to unconditionally defend, hold harmless and release from any and all liability the company and the individual that provided my treatment, the insured, and any additional insured's, as well as any officers, directors, or employees of the above companies for any condition or result, known or unknown, that may arise as a consequence of any treatment that I receive.

I have fully disclosed on my client intake form any medications, previous complications, or current conditions that may affect my treatment. I understand and agree that any legal action of any kind related to any treatment I receive will be limited to binding arbitration using a single arbitrator agreed to by both parties.

Date: _____

Client Signature: _____ Printed Name: _____

Model Release

In consideration for treatment received, I hereby grant permission to the individual or company that provided my treatment to use any photographic treatment records for the purposes of clinical and statistical studies, advertising, or promotion without any additional compensation to me.

Date: _____

Client Signature: _____ Printed Name: _____

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HIPAA Consent

I give Westchase Medspa my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care options like quality reviews. I give Westchase Medspa my consent to use or disclose my protected health information in order to obtain payment for services and/or product.

I have been informed that I may review Westchase Medspa's Notice Of Privacy Practices (for a more complete description on uses and disclosures) before signing this consent.

I understand that Westchase Medspa has the right to change their privacy practices and that I may obtain any revised notices at the clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Westchase Medspa is not required to agree to the request. If Westchase Medspa agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Patient, parent or legal guardian:_____

Signature:_____ Date:_____

If signed by patient representative, state relationship to patient:_____

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Pre & Post Treatments for Laser Hair Removal

Pre-treatment

- **Shave** treated area while it has full growth, as we want to direct laser energy into the hair follicle.
- **Laser treatments are not recommended for tanned patients until the tan has faded**. Sun exposure must be avoided between treatments for a ***minimum of three weeks before treatments***. This includes sun exposure and tanning booths. Artificial tanning products must be discontinued two weeks prior to treatments. **Always use a sunscreen (containing zinc oxide or titanium oxide) of SPF 30 or higher** throughout the course of your laser treatments. If you are aware that your skin stays tan longer than three weeks after sun exposure, schedule your appointment so that you are not tan on the day of treatment.
- **Do not pluck, wax or tweeze** throughout the course of your laser treatments.
- **No antibiotics** and/or any **photosensitive medications** may be used during the time of treatment.
- **No Retin - A, Tetracycline, Accutane** may be used.
- Patients with a history of herpes simplex 1 or 2, cold sores should be put on oral antiviral drugs (Zovirax or Famvir) beginning the day before treatment. Laser heat can trigger and/or reactivate the virus in the same way as sun, stress, and fever.
- At the time of treatment, laser protective glasses **MUST** be worn.
- If consuming any hormone stimulating or anti-depression medication, **client MUST** notify Technician prior to treatment.

Post-treatment

- **No DIRECT Sun Exposure or Tanning** three weeks after laser treatment. Change of pigmentation in the treated area will appear with combination of laser and sunlight. **Always use a sunscreen of SPF 30 or higher with ZINC oxide or titanium oxide.**
- Extra hygiene care at home is required.
- **DO NOT pluck, wax or tweeze** during the time of laser treatment
- Redness and swelling of the follicles/ tissue may appear and will remain for approximately 15 min up to few hours.
- To reduce swelling, an ice pack may be applied to the treated area. If **scabbing, pustules or follicle inflammation** appears, apply Hydrocortisone 1% or an antibiotic cream such as Neosporin, Polypore for 2-3 days after the treatment.
- **DO NOT TOUCH, RUB, and SCRATCH OR PICK** the treated area.
- Within a few days after the treatment, stubbles representing **dead hair follicles** will appear. Complete exfoliation takes anywhere from 10 – 20 days.

Should you HAVE any concerns or questions, please do not hesitate to call our office at (813) 749-7143. Our goal is Client satisfaction and to educate our Client, to fully understand the procedures of Laser Hair Removal/Reduction, HAVE confidence and cooperation in their decision.

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