



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

Microdermabrasion Client Informed Consent Form

Patient: _____

Date: _____

This consent form is designed to verify that you have been satisfactorily informed and educated in respect to your microdermabrasion skin care treatment, as well as its aftercare, so that you may make an educated decision as to whether to have this procedure performed. This disclosure is not meant to alarm you; it is simply an effort to make you better informed so you may give, or withhold, your consent for treatment. Please read and initial where indicated.

1. I acknowledge having been informed that this cosmetic procedure is intended to remove superficial surface layers of the skin to improve the vitality of the skin. **Initial here:** _____
2. I have not had used Glycolic, AHA or Retinol products for at least 7 days prior to treatment and further acknowledge that I will not use these products for at least 7 days post treatment. **Initial here:** _____
3. I understand that my skin care professional can discover other, or different conditions that may require additional or different procedures than those planned. If my skin care professional discovers such other or different conditions I will be referred to an appropriate medical care provider. **Initial here:** _____
4. It has been explained to me that because microdermabrasion procedures are a superficial abrasion to the skin, the result of a one-time treatment is similar to a deep cleansing or polishing of the skin. I understand that in order to see significant results these treatments need to be done in a series and in combination with active ingredient skin care products. **Initial here:** _____
5. I acknowledge that while the goal of such a procedure is the removal of damaged skin, the realistic results average at least fifty percent improvement. I acknowledge that the practice of cosmetology is not an exact science and that no specific guarantees can or have been made concerning the expected result. Some clients' skin may show improvement, while others may not show marked improvement. **Initial here:** _____
6. I acknowledge that after my microdermabrasion procedure, all treated areas may feel warm and appear sunburned or my skin may experience a wind-burned sensation. **Initial here:** _____
7. I understand that my compliance to my aftercare instructions will greatly affect my final result. I acknowledge my obligation to follow the written and spoken instructions covering my pre- and post-treatment skin care regimen. **Initial here:** _____
8. I understand that although rare, certain risks or complications could occur but are usually treatable and temporary, such as hyper-pigmentation, hypo-pigmentation, and scarring. Following all post procedure instructions will help avoid conditions. **Initial here:** _____
9. I acknowledge that if I am prone to Herpes (cold sores, fever blisters) that I may need a prescription for Valtrex (acyclovir) prior to having microdermabrasion. I need to avoid treatments during a breakout. **Initial here:** _____
10. I acknowledge that I have not used Accutane during the last six months. **Initial here:** _____
11. Acne patients, it has been explained to me that I may experience a slight acne flare-up, and that my acne condition may temporarily look worse for a few days after a microdermabrasion treatment. **Initial here:** _____
12. I acknowledge that I have been instructed to avoid sun exposure and must wear a sun block of at least SPF 25 over the treated areas on a daily basis during my treatment series. **Initial here:** _____
13. I understand that if I have any additional questions or concerns that I should call the office immediately. **Initial here:** _____

I have read and initialed each paragraph and have been satisfactorily informed of the benefits, risks, and complications regarding microdermabrasion. I consent to this microdermabrasion treatment today and for all subsequent microdermabrasion treatments.

Patient Signature: _____

Date: _____

Witness Signature: _____

Date: _____

Parent/Legal Guardian Signature (if patient is a minor): _____

Date: _____



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Confidential Patient Information

Name: _____ Date of Birth: _____ Age: _____ Sex: Male Female
 Address: _____ City: _____ State: _____ Zip: _____
 Homephone: _____ Cellphone: _____ Email Address: _____

Please check if you are affected by or have any of the following:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fever Blister | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Cardiac Problems D | <input type="checkbox"/> Headaches-chronic | <input type="checkbox"/> Immune Disorders | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lupus | <input type="checkbox"/> Skin Diseases-other |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Herpes | <input type="checkbox"/> Metal bone | <input type="checkbox"/> Urinary or Kidney Problems |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pins or plates | |

Are you... Pregnant? Trying to get Pregnant? Breastfeeding? Lactating?

Please choose the best match for yourself

What is your hereditary background? _____

Natural Eye Color: _____ Natural Hair Color: _____ Skin tone: _____

Do you consider your skin (Check all that apply):

- | | | | | |
|---|---------------------------------------|--|--|------------------------------------|
| <input type="checkbox"/> Normal | <input type="checkbox"/> Milia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Patchy Dryness | <input type="checkbox"/> Breakouts |
| <input type="checkbox"/> Dry | <input type="checkbox"/> Cysts | <input type="checkbox"/> Freckled | <input type="checkbox"/> Sallow | |
| <input type="checkbox"/> Dark Circles | <input type="checkbox"/> Acne-Scarred | <input type="checkbox"/> Melasma | <input type="checkbox"/> Psoriasis | |
| <input type="checkbox"/> Oily | <input type="checkbox"/> Large Pores | <input type="checkbox"/> Hyperpigmentation | <input type="checkbox"/> Dehydrated/lacking Moisture | |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Small Pores | <input type="checkbox"/> Hypopigmentation | <input type="checkbox"/> Telangiectasia/broken Surface | |
| <input type="checkbox"/> Comedones/blackheads | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Uneven/blotchy | <input type="checkbox"/> Capillaries | |

Do you consider your skin: Sensitive Resilient Unsure

Do you have any allergies to medications? (Please list all allergies on back of page.)

- | | |
|---|--|
| Do you have allergies to cosmetics, foods, or drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had skin cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have allergies to aspirin? <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever or are you now using Accutane? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you use or receive depilatories or waxing? <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you sensitive to alcohol based products? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you had collagen, Botox or other dermal filler injections? <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you use sunscreen daily? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you presently under a physician's care for any skin condition? <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you taking birth control or hormone replacements? <input type="checkbox"/> Yes <input type="checkbox"/> No |

If yes, please explain: _____

Do you have sensitive to any of the following? Yes No
 Milk Apples Citrus Grapes Aloe vera Aspirin Perfumes Latex Hydroquinone Mushrooms

Do you experience cold sores/fever blisters? Yes No Do you use tanning beds? Yes No

Have you recently had facial surgery? Yes No

If yes, what type of surgery? _____

Have you recently had laser resurfacing? Yes No

If yes, what type of treatments and when? _____

Do you smoke, use tobacco or live with a smoker? Yes No Do you often experience stress? Yes No

Do you have permanent make-up? Yes No Do you wear contact lenses? Yes No

Have you had professional skin care in the past? Yes No Do you participate in vigorous exercise or sports? Yes No

What skin care products do you currently use? _____

How many ounces of water do you drink daily? _____

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 in order 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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Face Treatment Form

Client's Name: _____

Date: _____ Technician: _____

Facial/body treatment type: _____

Products used: _____

(Micro) tip(s) used: _____

Skin reactions: _____

Notes:





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Client's Name: _____

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Facial/body treatment type: _____

Products used: _____

(Micro) tip(s) used: _____

Skin reactions: _____

Notes:

Send by Email

Print

Save