AESTHETIC LASER CENTER

Patient Intake

DATE:_____
NAME:_____ DOB:_____
ADDRESS:_____
CITY/STATE/ZIP CODE: _____
EMAIL: _____
CELL PHONE: (_____) _____-_____ OCCUPATION:_____
HOW DID YOU HEAR ABOUT US? (Include Referall's Name): _____

ARE YOU INTERESTED IN:

- ❑ **Body Sculpting**
- ❑ **Sun damage**
- ❑ **Redness/Rosacea**
- ❑ **Hair Removal/Restoration**
- ❑ **Stretch mark/Scar Reduction**
- ❑ **Anti-Aging/ Resurfacing**
- ❑ **Skin care/ At home care**
- ❑ **Injectables**
- ❑ **Acne**
- ❑ **Tattoo Removal**

Have you had any laser/aesthetic procedures before? If yes, please list:
_____
_____

MEDICAL AND LIFESTYLE HISTORY:

Have you ever had any of the following conditions?:

- ❑ Heart Disease
- ❑ Kidney Disease
- ❑ Anemia
- ❑ Diabetes
- ❑ Cold sores/Fever Blister
- ❑ High Blood Pressure
- ❑ Bleeding Disorders
- ❑ Keloid Scarring
- ❑ Metal Implants
- ❑ Eating Disorder
- ❑ Dermatitis
- ❑ Seizures
- ❑ Liver Disease
- ❑ Cancer
- ❑ HIV/Hepatitis

If yes, please explain: _____
_____

_____

Are you/Do you:

SMOKE YES NO How Often?
_____

DRINK YES NO How Often?
_____

EXERCISE YES NO How Often?
_____

TANNING BOOTHS YES NO How Often?
_____

PREGNANT /NURSING YES NO

Do you use any of the following topical/oral medications?

- ❑ Accutane
- ❑ Retin-A/Retinol
- ❑ Hydroquinone
- ❑ Adapalene/Differin
- ❑ Topical Antibiotics
- ❑ Oral Antibiotics
- ❑ Hydroquinone
- ❑ Renova/Refissa/Tretinoin
- ❑ Tazorac/Tazarotene/Avage

Please list all Prescription Medications and Supplements: _____
_____
_____

Please list all Food and Drug Allergies: _____
_____
_____

APPOINTMENT POLICY AND CHECK IN

If you need to reschedule or cancel your appointment, please give us 24-hour notice when possible. If you fail to let us know you cannot make your appointment (No Show within 24 hours), your account will be charged a $45 inconvenience fee.

I, _____, acknowledge and agree to these terms.

_____ _____
Signature of Client/Guardian Date

PHOTO CONSENT

I,_____, authorize Aesthetic Laser Clinic. and its staff to take before, during and after photographs or videos of procedures performed on me. I understand that these will be used to determine efficacy and for quality control measures.

May we use your photographs in social media posts/marketing materials/etc? We will not include your name or any identifying features without further consent.

YES, I consent to my photographs to be used. NO, I do not consent to my photographs to be used

_____ _____
Signature of Client/Guardian Date

NON-REFUNDABLE CLAUSE

Patients understand that once the purchase of services has been issued and paid, there will be no refund to the patient. The patient may apply purchase price to a different service, however the price of intending service will remain at its original cost.

_____ _____

Signature of Client/Guardian Date

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Aesthetics Questionnaire

Name:_____**Date:**_____

Please rate the following symptoms on a scale of 0-10. 0 Being no problem and 10 being the worst problem.

Symptom	Pre-treatment	Treatment 1	Treatment 2	Treatment 3
1.Pore size				
2. Crows feet				
3. Lip lines				
4.Brown spots				
5. Redness/vein				
6. Thinness(eyes)				
7.Thinness(neck)				
8.Thinness(face)				
9. Texture				
10.Black heads				
11. Acne				
12. Frown lines				
13. Labial Folds				
14. Marionettes				
15. Slack in skin				
16. Other				

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CONSENT FOR LASER/LIGHT-BASED and AESTHETIC TREATMENT

I authorize _Aesthetic Laser Clinic of Beaumont_____ to perform laser/pulsed light and micro needling/radio frequency cosmetic skin treatments on me, including, but not limited to, the treatment of pigmented lesions (for example, sun spots, age spots, and other skin discolorations), vascular lesions tattoo removal, wrinkles, (rhytides), furrows, fine lines, textural irregularities, non ablative skin resurfacing, soft tissue coagulation, ablative skin resurfacing, and reducing or eliminating hair. I understand that PRP therapy may be used as a stand alone treatment for hair loss or an add on treatment to any of my aesthetic treats to expedite the healing process.I understand that the procedure is purely elective, that the results may vary with each individual, and multiple treatments may be necessary. I understand that: All personnel in the treatment room, including me, must wear protective eyewear to prevent eye damage from this light energy. The sensation of light is sometimes uncomfortable and may feel like a moderate to severe pinprick or flash of heat. Anesthesia or sedation (calming medication) may be advisable for laser skin resurfacing treatments. If the practitioner or physician elects to use an anesthetic to reduce discomfort during any light-based treatment, all options and risks associated with the anesthetic will be discussed with me. The treated area may be red and swollen for two to twenty-four (2–24) hours or longer. Cooling the area after the treatment (for example, ice packs, topical gels) may help reduce discomfort and swelling. Common side effects include temporary redness (erythema) or mild "sunburn"-like effects that may last a few hours to 3-4 days or longer. Other potential side effects include, but are not limited to, crusting, irritation, itching, pain, burns, scabbing, swelling (edema), broken capillaries, bronzing, and acne or herpetic breakouts. There also is a risk of resulting unsatisfactory appearance and failure to achieve the desired result. Pigment changes, including hypo pigmentation (lightening of the skin) or hyperpigmentation (darkening of the skin), lasting one to six (1-6) months or longer or permanently may occur. Freckles may temporarily or permanently disappear in treated areas. Serious complications are rare but possible, such as scarring, blood clots, skin loss, hematomas (collection of blood under the skin), and allergic reaction to medications or materials used during the procedure. I understand and accept that with skin resurfacing treatments, there may be an increased length of social downtime associated with the level of treatment. There also is a chance of additional side effects like blanching and significant redness. With ablative laser treatments, there are additional risks of discomfort, focal areas of bleeding, bruising, poor healing, serous discharge, and infections. Serious but rare complications may include scarring, abscess, skin necrosis (dead skin), and injury to other internal structures including nerves, blood vessels, or muscles. An occlusive ointment may be used to cover the treated skin and keep it moist to avoid the skin drying out and being crusty or desquamated. Occlusion may exacerbate acne breakouts under the ointment. There is no guarantee that the expected or anticipated results will be achieved.

Sun, tanning bed, or tanning lamp exposure, the use of self-tanning creams, and not adhering to the post-treatment instructions provided to me may increase my chance of complications. I must avoid the sun, tanning beds, and sunless tanning lotions and use sunblock (SPF 50 recommended) after treatment. There is a possibility of coincidental hair removal when treating pigmented or vascular lesions in hair-bearing areas. There is a risk that the hair regrowth may be changed, such as little or no regrowth or more regrowth than before. I should call my provider as soon as possible if I have any concerns about side effects or complications after treatment. I hereby consent to the administration of any anesthesia or sedation considered necessary or advisable for my procedure(s). I understand that all forms of anesthesia and sedation involve risk and the possibility of complications, injury, and in rare instances death. Not providing my medical history before proceeding with a light-based treatment could impact treatment results and cause complications. I consent to photographs and digital images being taken and used to evaluate treatment effectiveness, for medical education, training, professional publications or sales purposes. No photographs or digital images revealing my identity will be used without my written consent. If my identity is not revealed, these photographs and digital images may be used, shared, and displayed publicly without my permission. Before and after-treatment instructions have been discussed with me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction. I have read and understand all information presented to me before consenting to treatment. I have had all my questions answered. I freely consent to the proposed treatment today as well as for future treatments as needed.

Signature: _____ Date _____
Print name: _____
Witness signature: _____ Date: _____
Print name: _____

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Pre/Post Care for Laser Treatment

Contraindications include use of medications that increase photosensitivity (such as certain antibiotics or Accutane), use of anticoagulants or have had chemotherapy in the past 6 months, history of bleeding disorders, pregnancy/breastfeeding, and seizures disorders. Prednisone and other steroids can cause excess swelling post treatment for up to 2 weeks. PLEASE ADVISE YOUR LASER PROVIDER IF YOU HAVE ANY OF THESE CONDITIONS.

Pre-Care Instructions

- Sun, tanning bed or the use of self tanning creams are not to be used 2 weeks prior to treatment.
- SPF 50 sunblock in the minimum required to the treatment areas 2 weeks prior to treatment
- Avoid skin care, cleansers and toners that contain Retinol A, glycolics, salicylic acid, witch hazel, benzoyl peroxides, alcohol, vitamin C, etc. If you have a question about your skincare or make-up please contact your technician prior to treating and understand that if you are using one of the listed ingredients it will postpone your treatment.
- Please do NOT take any steroids, anti-inflammatories(IBUprofen, or Aleve, etc.) 24 hours before a treatment.

Post-Care Instructions

- It is very important to ice when you are able , no more than 10 minutes every 4 hours for the first 2 days to reduce swelling for 1540/microneedling and vascular treatment
- NO Aleve/Ibuprofen 48 post treatment
- Showers can be taken, but please try to avoid hot water and direct shower spray to the treatment area for 48-72 hours following treatment. Avoid all saunas and hot tubs.
- Avoid strenuous exercise for 48 hours (this includes hot yoga).
- Sleep with 1-2 extra pillows at night to keep head raised for the first 2 nights if swelling is present
- Do not use any retinoid, RETIN-A or GLYCOLIC products for 1-2 weeks post-procedure. Do not use any non-prescription creams without discussing it with your provider first.
- Refrain from any chemical peel treatments or microdermabrasion for 4 weeks post-procedure.
- Avoid scratching, rubbing the treated skin – do not put adhesive dressings over treated areas. Itching after a treatment is part of the healing process, taking a non drowsy over the counter antihistamine is recommended as needed.
- Men may shave 3 days post-treatment but be gentle.
- Avoid direct sunlight for a minimum of 4 weeks after your treatment. Wear a provider approved physical sun protection for the next 4 weeks. If actively outdoors, you should re-apply your sunscreen every 2 hours and wear a wide-brimmed hat.

_____I have read the above pre/post care instruction and willingly comply with all pre and post care protocols directed by Aesthetic Laser Clinic.

_____I understand that not adhering to the safety protocols stated above, that there is a potential of first and second degree burns, prolonged swelling, purpura and induced pigmentation.

Patient Signature:_____

Date:_____

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Arbitration Agreement

Article 1: Agreement to arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.
Article 2: All claims must be arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement binds all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a backup for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damage exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief or punitive damages.

Article 3: Procedures and applicable law" A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter and located within the clinics county. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with the other expenses incurred by a party for such party's own benefit.
Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in the arbitration of any person or entity that would otherwise be an additional person or entity shall be stayed pending arbitration.

The parties agree that the provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgement for future damages conformed to periodic payments, shall apply to the dispute within the Arbitration Agreement. The parties further agree that the commercial Arbitration rules of the American Association shall govern any arbitration conducted pursuant to the Arbitration Agreement.
Article 4 : General provisions: All claims based upon the same incident, transaction, or related circumstance shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.
Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.
Article 6 : Retroactive effect: If a patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) the patient should initial here___. Effective as the date of the first professional service.

If any provisions of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. see article 1 of this contract.

Patient Signature_____Date_____

Office Signature_____Date_____