

**INFORMED CONSENT FORM FOR MULTIPOLAR RADIOFREQUENCY TREATMENTS**

Beauty Institute and Spa Inc.

*Privet and Confidential*

Full Name: \_\_\_\_\_

Birthdate: (d/m/y) \_\_\_\_\_ Sex:  F  M

Address: \_\_\_\_\_

City: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone: \_\_\_\_\_

**Medical history**

- Pregnancy or nursing (current only).
- Heavy menses/bleeding.
- Dental implants, braces, caps, metal fillings (amalgams, gold) - for facials, please circle all that apply.
- Botox or filler in treatment area.
- Pacemaker or internal defibrillator, implanted neuro-stimulators or other internal electric device.
- Metal implants or other implants in the treatment area- ie. IUD, screws, plates.
- 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, or use of Immune suppressive medications.
- Active weeping acne.
- Continuous use of Retin A, retinol.
- Herpes (active).
- Medications such as blood thinners.
- Skin blotches or rosacea.
- 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.
- 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.
- Chemical sensitivities such as reactions to cosmetic products or perfumes. If known, please list specific offending ingredients: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_.
- Varicose veins in the treatment area.
- 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.

**Please initial here \_\_\_\_\_ to acknowledge that you read this page.**

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**Disqualifying Conditions for Multipolar Radio Freuqncy Treatments**

Check off in not applicable

No

Implants: heart pace-maker, braces, cochlear, or any other artificial organ inside the body

Pregnancy

Lactation

Tuberculosis

Not feeling thermal changes

A burn or care after such a burn

Active cancer

Severe active arthritis

Active gout

Severe cardiovascular disease, circulation troubles (thrombus arterial sclerosis, etc.)

No

Coagulation disorder or bleeding tendency

Acute hernia, discopathy, spondyloslysis

Migraines and Epilepsy

Malignant Tumors

Acute infections or inflammations

Acutane and retinol

Botox or filler in treatment area

Suppuration of soft tissues

Kidney stones

Any active condition in the treatment area, such as Herpes, sores, psoriasis, dermatitis, eczema and rash

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 was told to **hold the safety switch** during the treatment. **It should be pressed if the heat is too hot.**

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 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. **Money for prepaid packages is non-refundable**, however, credit for services yet-to-be delivered may be applied to receiving any other services or products offered at Beauty Institute and Spa (credits are calculated on non-package pricing).

**Cancellation of appointments** without rescheduling must be done **48 hours** prior the appointment to avoid treatment fee charges.

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

Client Initials: \_\_\_\_\_ Aesthetician Initials: \_\_\_\_\_

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

\_\_\_\_\_  
Patient name (print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Clinical therapist signature