Nagada MedSpa

Informed Consent/Cancellation Policy

Patient's Name: _____

I duly authorize Nagada MedSpa to perform laser hair removal procedure measures, which in their opinion may be necessary.

The purpose of this procedure is to diminish or remove unwanted hair. The procedure requires more than one treatment and may produce permanent hair reduction. The total number of treatments will vary between individuals. On occasion there are patients that do not respond to treatments.

The following may occur with laser hair removal system:

- However slight, there is a risk of scarring.
- Short-term effects may include mild burning, and temporary reddening, scabbing, bruising or blistering. Hyper-pigmentation (browning) and hypo-pigmentation (lightening) have been noted after treatment. These conditions usually resolve within 3-8 months. I understand there are rare side effects such as scarring and permanent color change. Avoiding sun exposure before and after the treatment reduces the risk of color change.
- Clinical results may vary depending on individual factors, including medical history, skin and hair type, patient compliance with pre/post treatment instructions, and individual response to treatment.
- Allergic reactions: In rare cases, local allergies to botanicals, aloe, arnica, and preservatives used, in the topical preparation, during pre/post laser of skin may occur. All allergies need to be reported to practitioner and recorded medical information.
- Topical preparations have been reported. Systemic reactions (which are more serious) may result from prescription medicines**. Please report any change in medical condition prior to each treatment.**

I understand that exposure to the light could harm my vision. I must keep the eye protection goggles on at all times.

Cancellation Policy

Please provide a minimum notice of 24 hours to cancel or reschedule appointments. If the required notice time has expired, or you fail to give any notice whatsoever (no show), you will be billed $20 per scheduled service area or "one service" whichever is greater.

ACKNOWLEDGMENT:

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I am not pregnant at this time, and that I have not taken Accutane within the last 6 months. I do not have a pacemaker or internal defibrillator

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release Tracy Buskirk-Koch RE CCE CME and supervising physician Dr. Donald Willem DO from all liabilities associated with the above indicated procedure.

Patient Signature _____ Date_____

Witness _____ *Guardian signature if client is under 18

Nagada MedSpa

Client Information & Medical History

In order to provide you with the most appropriate laser treatment, we need you to complete the following questionnaire. All information is "strictly confidential".

Personal History

Client Name_____ Date of Birth _____ Age_____

Home Address_____ City_____

State_____ Zip_____ Occupation_____

Contact Phone_____ Cell Phone provider_____

E-Mail_____ email updates OK? ☐Yes ☐ No

Emergency Contact: Name & Phone_____

How were you referred to us? _____

Which of the following best describes your skin? (Please circle one)

Always burns, never tans	Rarely burns, always tans
Always burns, sometimes tans	Brown, moderately pigmented skin
Sometimes burns, always tans	Black skin

Medical History

Are you currently under the care of a physician? ☐Yes ☐ No

If yes, for what? _____

Are you currently under the care of a dermatologist? ☐ Yes ☐ No

If yes, for what? _____

Do you have a history of erythema abgne (EAI)? This is a persistent skin rash produced by pro- longed or repeated exposure to moderately intense heat or infrared irritation.

☐Yes ☐ No

Do you have any of the following medical conditions? (Please check all that apply)

☐ Cancer ☐ Frequent Cold Sores ☐ Seizure disorder

☐ Skin disease/Skin lesions ☐ High Blood Pressure ☐ Keloid scarring

☐ Blood clotting abnormalities ☐ Hormone imbalance ☐ Thyroid imbalance

☐ Diabetes ☐ HIV/AIDS ☐ Arthritis

☐ Herpes ☐ Any active infection ☐ Hepatitis

Do you have any other health problems or medical conditions? Please list:

_____

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced)

Food _____

Latex _____

Aspirin_____

Lidocaine_____

Hydrocortisone_____

Hydroquinone or skin bleaching agents_____

Other_____

<u>Medications</u>

What oral medications are you presently taking? ☐ Birth Control Pills ☐ Hormones ☐Other (Please list)_____

Are you on any mood altering or anti-depression medication? ☐ Yes ☐ No

Have you ever used Accutane? ☐ Yes ☐ No If yes, when did you last use it? _____

Are you using any topical medications or creams? ☐ Retin–A ☐ Other (Please list)

_____

_

What herbal supplements do you use regularly?_____

<u>Medical</u>

Have you ever had laser hair removal? ☐ Yes ☐ No

Have you used any of the following hair removal methods in the past six weeks?

☐ Shaving ☐ Waxing ☐ Electrolysis ☐ Plucking ☐ Tweezing ☐ Stringing ☐ Depilatories

Have you had any recent tanning / sun exposure that changed the color of your skin? ☐ Yes ☐ No

Have you recently used any self-tanning lotions or treatments? ☐ Yes ☐ No

Do you form thick or a raised scar from cuts or burns? ☐ Yes ☐ No

Do you have hyper pigmentation (darkening of the skin) or Hypo pigmentation (lightening of the skin) or marks after physical trauma? ☐ Yes ☐ No if yes, please describe:

_____

_

For our female clients:

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Are you using contraception? ☐ Yes ☐ No

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures

Signature _____