

# HydraFacial™ Consent Form

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

HydraFacial is the only hydradermabrasion procedure that combines cleansing, exfoliation, extraction, hydration and antioxidant protection simultaneously, resulting in clearer, more beautiful skin with little-to-no downtime. The treatment is soothing, moisturizing, non-invasive and generally non-irritating. As with most procedures, visible results from HydraFacial will vary from person to person.

**Do you have any of the following allergies?**

YES NO

- Shellfish
- Aspirin
- Sulfur
- Preservatives

Other, please explain: \_\_\_\_\_

**Contraindications:**

YES NO

- Accutane or other similar medication
- Autoimmune disease, HIV, lupus, hepatitis
- Blood thinners – Heparin, Coumadin, Warfarin, etc.
- Breastfeeding, pregnancy
- Cancer or post-cancer treatments
- Cardiovascular problems
- Cold sores or fever blisters without pre-medication
- Cortisone or steroid injections
- Cosmetic injections, fillers or implants, (i.e. Botox®, collagen)
- Eczema, psoriasis
- Enlarged or painful glands

YES NO

- Epilepsy
- Facial waxing services w/in 7-14 days
- Heart ailment
- Hypertension/high blood pressure
- Inflammatory conditions
- Irregular, pigmented moles, warts or growths, unidentified facial growth or mark
- Keloids, pigmented scars, icepick scars, new scar tissue
- Laser procedures, chemical peels, dermabrasion, microdermabrasion
- Light sensitive medication
- Loose, thin, aged skin
- Lymphatic disorder, inflammation of lymph vessels, lymphedema

**Medication, list here:**

YES NO

- Pacemaker or metal implants
- Phlebitis, varicose veins
- Recent accident or serious injury
- Recent surgical or dental procedure
- Rosacea, telangiectasia/couperose
- Retin-A, Retinol
- Skin abrasions or lesions
- Other

\_\_\_\_\_

YES NO

- Stage III or IV acne
- Skin-lightening or bleaching agent
- Sunburn
- Swollen or infected tonsils
- Thyroid conditions
- Type I diabetic
- Under medical care for an existing or suspected condition or disease
- Viral infection, influenza

# HydraFacial™ Consent Form

Please Initial:

\_\_\_\_\_ Before receiving treatment, I have communicated with the Practitioner about any conditions or medications that may contraindicate this procedure.

\_\_\_\_\_ I acknowledge that I have not used Accutane or any medication for the same purpose during the last 12 months.

\_\_\_\_\_ I acknowledge that if I have ever had a cold sore or fever blisters, I should consult with my physician or pharmacist for a pre-use medication to help avoid a possible breakout. That medication should be used each day for two days before, same day, and two days after any aggressive facial exfoliation treatment

\_\_\_\_\_ I acknowledge that there is no guarantee that dark discoloration of skin will be reduced or fade. Pigmentation may improve or darken with successive treatments. I acknowledge the need for a proper skincare home regimen.

\_\_\_\_\_ I acknowledge that my skin might experience temporary irritation, tightness, redness, or slight swelling, which usually dissipates within 72 hours, depending on skin sensitivity.

\_\_\_\_\_ I have disclosed my history of allergies above.

\_\_\_\_\_ I acknowledge that if I am allergic to one or more of the ingredients in the products used, I may experience allergic reactions.

\_\_\_\_\_ I acknowledge that if I fail to use minimal sunscreen (SPF 30) and follow the direction for use, I am more susceptible to sunburn, sun damage & hyperpigmentation. I should avoid excessive sun exposure, especially between 10 am - and 2 pm.

\_\_\_\_\_ I acknowledge that this treatment is strictly an elective cosmetic procedure and that no medical claims have been expressed or implied.

\_\_\_\_\_ I acknowledge that I am not pregnant/lactating.

\_\_\_\_\_ I acknowledge that I should avoid the use of aggressive exfoliation, waxing, and products containing acids that are not part of the recommended take-home regimen for 2-4 weeks following the treatment.

\_\_\_\_\_ I acknowledge that I should avoid using Retin-A type products for a period of time recommended by my physician and/or skincare practitioner during and following the treatment.

\_\_\_\_\_ I acknowledge that I have answered all questions truthfully, and I release Evergreen Cosmetic Laser, their management, and staff from any and all liability associated with any current or future skincare procedures or products.

The nature and purpose of the treatment have been explained to me. I have read and understood this agreement in its entirety that I completed on "today's date" stated on pages one of two on this consent form. All of my questions have been answered to my satisfaction, and I consent to the terms of this agreement. Alternative treatment methods and their risks and benefits have been explained to me, and I understand that I have the right to refuse treatment. 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 update my records. Recent medical history is essential for the caregiver to execute appropriate treatment procedures.

\_\_\_\_\_  
PRINTED NAME OF PATIENT (FIRST, LAST)

\_\_\_\_\_  
PATIENT SIGNATURE  
(OR SIGNATURE OF LEGAL GUARDIAN IF PATIENT IS UNDER 18)