The Humber Spa

CONSENT FORM - ANGELITE & SOPRANO HAIR REMOVAL

Patient Name: _____

Treatment Sites: _____

1. I understand that the Angelite and Soprano are devices used for hair removal and that clinical results may vary in different skin types and their hair types. The goal of this treatment is improvement not perfection. I understand there will be some hair left at the end of my treatments. Clinical results may vary depending on individual factors, including: fluence (energy) I can tolerate, color, density and location of hair growth, medical history, patient compliance with pre/post treatment and individual response to treatment. Average loss at the end of consecutive sessions is 70 – 95% less hair. Up to 20% of the population does not respond to any laser or light treatments.
2. I understand that treatment by the Angelite and Soprano hair removal systems involves a series of treatments and there may be more treatments necessary than I anticipated. The Angelite and Soprano in studies has shown to reduce hair permanently but results can vary from person to person.
3. The fee structure has been fully explained to me. I agree to pay the fee quoted and understand that all fees quoted are non-refundable.
4. I agree to have clinical photos taken of the area to be treated as required. I require written permission prior to my photos being used for public display.
5. Studies and experience with this technology have shown these to be some potential complications and side effects.
   - 10 – 20 % chance of developing hypo and/or hyper pigmentation
   - Pimples, redness, swelling, blistering and scabbing
   - Temporary bruising
   - Freckles and brown spots may lighten and disappear
   - Ingrown hairs
   - Purple mottling discoloration can occur with hair removal on legs
   - New reports are documenting the incidence of increased growth of facial hair on females especially in the neck area and it may not resolve with further treatments
6. I understand that if I have a history of cold sores or genital herpes I may require pre and post treatment with anti viral medications.
7. I confirm that I am not pregnant. I do not have a pacemaker or internal defibrillator. I confirm I have not undergone any treatment for cancer within the last 5 years and I do not have poorly controlled diabetes.
8. I confirm that I have not taken Accutane within the last 6 months; I have not had laser resurfacing in the last 6 months; I have not had deep chemical or mechanical peeling and have not had Botox or injectable fillers in the last 2 weeks. I am not photo allergic and I do not have a history of keloid scarring. I do not have a spray tan at this time and I do not have permanent tattoos on the treatment site.
9. I agree that I have not tweezed, waxed, threaded or had electrolysis for the past 4 weeks.
10. I agree not to tan while undergoing laser and /or IPL treatments. I agree to protect my skin with a minimum of an SPF Sun Block 30 for each 4 – 12 post treatment.
11. I understand that my medication _____ which is known to be photosensitizing increases my chance of developing blisters. I am willing to accept that risk.
12. I understand that to have the best result possible I agree to the treatment intervals as the clinic designs for me. I agree to follow post care instructions.
13. I will inform the technician of any changes to my medical history and/or medications taken during the course of the Photo pneumatic hair removal treatment sessions.

I certify that I have been fully informed of the nature and purpose of the procedure. I understand the potential benefits and possible complications, and I understand that no guarantee can be given as to the final result obtained. I willingly agree to undergo Angelite or Soprano hair removal treatments. I certify that I am a competent adult of at least 18 years of age.

Date: _____ Client Name: _____ Signature: _____

I have reread this consent prior to my next treatment and agree that there have no changes in my health or medical condition. I acknowledge that I understand the 14 statements in this consent.

Date: _____ Client Name: _____ Signature: _____

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PULSED LIGHT TREATMENT PATIENT INFORMED CONSENT

I _____ understand that I am a candidate for the Soprano Laser and/or the Anglelite IPL treatment(s) (hereinafter referred to as the "procedure"). I have reviewed and understand the information given to me and I have discussed all aspects of the specific procedure that I am to receive.

The nature of the procedure, the possible complications and risks as well as the possible benefits of the procedure, the alternatives to the procedure and the risks and benefits of those alternatives have been explained to me in a language and in terminology that I understand. Representative staff including the operator/technician who will be performing the procedure and others who represent the organization and may have been engaged in the consultation describing the procedure (hereinafter the "staff") have answered all of my outstanding questions about the procedure. None of the staff have made any promises or warranties or guarantees as to the success or effectiveness of the procedure. The goal of the procedure and the outcome can be influenced by many factors. I understand that 15% if the population does not respond to pulsed light treatments. I also understand that there may be a requirement for more treatments than originally anticipated. I agree to pay the fee quoted and I understand that all fees quoted are non-refundable.

I understand that there are numerous risks and complications, both known and unknown, connected to the procedure. Studies and experience with these procedures have included, but are not limited to, these potential complications/side effects; 10 – 20% chance of developing hypo/hyperpigmentation, , bruising, blistering, crusting, freckles and brown spots may lighten and disappear, pimples, redness and swelling, and recent reports have indicated 10% of females being treated in the neck area have documented a slight increase in hair growth. I understand that if I am using topical anesthetics I am solely responsible for their effects in combination with the procedure.

I understand that the procedure is a relatively new procedure and that minimal data exists concerning its long term safety and effectiveness. I understand that certain medications that I am on which are know to be photosensitizing, will increase my chances of contraindications including pigment changes and blistering. I understand that I will need certain post-care which has been explained to me. If at any time after the procedure I require additional medical attention related to the procedure, I will contact staff within 24 hours of the initial care. I have had the opportunity to ask questions about the procedure and all of my questions have been answered satisfactorily. I understand that in order to achieve the best possible results, I agree to the treatment intervals staff prescribes for me. I give staff permission to use the data associated with my treatment for research purposes. I understand that my name and personal identifying information will remain confidential, unless I give written permission to disclose this information (client may delete this clause when choosing not to participate in research activities).

I am not under the influence of any sedative. I am of clear mind and understand the nature of the procedure and the possible risks related to the procedure.

I understand that by signing below, I am indicating that I have read and understood the information in this patient consent form, that I have been verbally advised about the procedure, that I have had an opportunity to ask questions and that I authorize and consent to the performance of this procedure;

Patient Name:_____ Patient Signature:_____

Staff Name:_____ Staff Signature:_____

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LASER TREATMENTS/ PULSED LIGHT TREATMENT

First Name: _____ Date: _____

Last Name: _____

Address: _____

Phone Number: _____ Alternate Phone Number: _____

Date of Birth: _____

1. Have you had laser or pulsed light treatments in the past? Yes ◯ No ◯
   If yes, where on the skin? _____
2. Do you currently sun tan? _____ Use self-tanners? _____
3. When was your last exposure to sun tanning? _____
4. Skin type (when exposed to the sun without protection for about 1 hour)
   Always burns, never tans ◯ Always burns, sometimes tans ◯
   Sometimes burns sometimes tans ◯ Always tan ◯
5. Hispanic ◯ Asian ◯ Mediterranean ◯ Middle Eastern ◯ Black ◯
6. Are you planning a holiday in the sun? Yes ◯ No ◯
7. Reason for visit (area to be treated): _____
8. Are you currently taking any of the following medications?
   Acne Medications (i.e. Accutane) ◯ Medications, Creams, Make-up containing Retin-A ◯
   Antidepressants ◯ Antihistamines ◯
   Diuretics ◯ Anti-inflammatory Medication ◯
   Hypoglycemics ◯ Herbals (St. John's Wort, etc.) ◯
   Hormones (Oral Contraceptives) ◯ Antipsychotics ◯
   Other, Please specify; _____
9. Do you currently have a chronic medical illness you are being treated for? Yes ◯ No ◯
10. Have you ever had any form of cancer? How long ago? Yes ◯ No ◯
11. Do you have any allergies? Any allergies to medication? Yes ◯ No ◯
    If Yes, specify; _____
12. Are your menstrual periods regular? Yes ◯ No ◯
13. Do you have a history of Herpes Simplex at the treatment area? Yes ◯ No ◯
14. Do you have a history of keloid scarring? Yes ◯ No ◯
15. Are you taking any anticoagulants? Yes ◯ No ◯
16. Do you have a history of pigmentary reactions such as Melasma? Vitiligo? Yes ◯ No ◯
17. Have you had any facial treatments, including microdermabrasion? Or peels? Yes ◯ No ◯
    If Yes, when; _____
18. Have you used exfoliating creams in the past 2 weeks? Yes ◯ No ◯
19. Have you tweezed, waxed, sugared or had electrolysis on the treatment area in the past 4 weeks? Yes ◯ No ◯
20. Have you had any tattoos or permanent makeup anywhere on your body? Yes ◯ No ◯
    If Yes, specify; _____

What is your daily skin care routine?

_____

Additional Comments or Concerns:

_____