# **Client Health History:** Laser/ Light Energy Health History Intake

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home/Cell Phone: _____ Work: _____

Email: _____ Preferred Contact: Cell____ Work ____ Email ____

Emergency contact name: _____ Phone _____

Relationship to you: _____

**SKIN TYPE:** Review the skin types below, using the Fitzpatrick Scale, and check the one that best describes your skin. This information will be used by your technician to determine the most appropriate way to approach your treatment(s):

- ❑ I. Very fair skin; blonde or red hair; light-colored eyes; freckles common
- ❑ II. Fair skinned; light hair, light eyes
- ❑ III. Very common skin type; fair; eye and hair color vary
- ❑ IV. Mediterranean Caucasian skin; medium to heavy pigmentation
- ❑ V. Mideastern skin; rarely sun sensitive
- ❑ VI. Black skin; rarely sun sensitive

Are you of Asian heritage (Class V) and/or have a history of keloid scarring? ❑ Yes ❑ No

**Please list the products you use regularly:**

Facial Cleanser _____ Moisturizer _____

Toner _____ Serum _____

Scrubs _____ Sunscreen _____

Retinol _____ Glycolic Acid _____

Enzymes _____ Peptides or Growth Factors _____

**Cosmetic History**

How would you describe your skin? Normal___ Combination___ Oily___ Dry____

When were you last exposed to the sun (including tanning beds)? _____

Do you use sunless tanning products? Yes ____ No ____ If yes, when was it last applied? _____

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? Yes ___ No___ If yes, please describe _____

_____

Have you had laser treatments in the past? Yes ___ No___ What body area was treated? _____

_____

Describe your experience _____

Continued ⇨

**Client Health History:** Laser/ Light Energy Health History Intake continued

Have you used Accutane in the past year? Yes____ No____

Are you using any topical creams, lotions, or oral antibiotics for acne, cancer, antiaging or hyperpigmentation?

Please List: _____

Have you ever had any of the following injectables or implants?

| | | | | |
|---|---|---|---|---|
| Botox | Radiesse | Perlane | Collagen | Dysport |
| Juvederm | Restylane | Silicone | Sculptra | |

Other: _____

If yes, when? _____ What body area(s)? _____

Have you had any other cosmetic surgeries/procedures? Yes ___ No___ If yes, when?_____

What body area?_____

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

___Shaving ___Waxing ___Tweezing ___Threading ___Depilatories

**Health History**

Have you had chemotherapy in the past 6 months? Yes___ No___

Do you have moles/skin growths in the area to be treated? Yes___ No___

Have you ever had a reaction at the dentist or any other time from numbing? Yes___ No___

Do you have any allergies to medications, food, latex, topical products, and/or other substances? _____

_____

Do you have any of the following conditions:

___ Epilepsy ____Eczema ____Dermatitis ___Hormone imbalance ____Pregnancy and/or breastfeeding

____Autoimmune disease ____Herpes Simplex ____Diabetes

Do you have any other health condition not mentioned here? Yes___ No___ If yes, please list _____

_____

Do you form thick or raised scars from cuts or burns? Yes___ No___

Have you consumed drugs or alcohol in the last 24 hours? Yes___ No___

Have you undergone any recent surgery? Yes___ No___ If yes, please explain _____

_____

Please list all vitamins and supplements including herbal remedies you take regularly _____

_____

Please list all current medications including aspirin, ibuprofen, blood thinners, etc. you take regularly _____

_____

Is there anything else you would like us to know? _____

_____

**Client Health History:** Laser/ Light Energy Health History Intake continued

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 esthetician of my current medical or health conditions and to update this history. A current medical history is essential to execute appropriate treatment procedures.

Client Name (Printed) _____

Client Name (Signature) _____ Date: _____

Esthetician/Technician: _____ Date: _____

PATIENT NAME:

# 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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

**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, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare 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 the occurrence giving rise to any claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the healthcare provider, including those working at the healthcare provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, and/or the healthcare 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. This agreement is intended to create an open book account unless and until revoked.

**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) and provide National Arbitration and Mediation ("NAM") with the party arbitrator's contact information within thirty days of the date Respondent files its initial responsive pleading. A third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties from a list of arbitrators supplied by National Arbitration and Mediation ("NAM") within thirty days thereafter. The list supplied by NAM shall be a list of between 5 and 10 arbitrators, depending upon availability. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or 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 damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that 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 judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that, where not in conflict with this agreement, the Healthcare Malpractice Dispute Resolution Rules and Procedures of NAM shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of NAM rules are available on its website at https://www.namadr.com or by calling 1-800-358-2550 to request a copy of the rules.

**Article 4: General Provision:** All claims based upon the same incident, transaction, or related circumstances 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 healthcare 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 patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: _____ Signature: _____ Date: _____

**ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE**

# CONSENT TO LASER/LIGHT ENERGY TREATMENT

**NAME** _____ **DATE of BIRTH** _____

**ADDRESS** _____

**CELL PHONE** _____ **WORK PHONE** _____ **EMAIL** _____

**SKIN TYPE:** Review the Fitzpatrick Scale skin types below and check the one that best describes your skin. This information will help your technician determine the most appropriate way to approach your treatment(s):

- ☐ I. Very fair skin; blonde or red hair; light colored eyes; freckles common.
- ☐ II. Fair skinned; light hair, light eyes.
- ☐ III. Common skin type; fair; eye and hair color vary.
- ☐ IV. Mediterranean Caucasian skin; medium to heavy pigmentation.
- ☐ V. Mideastern skin; rarely sun sensitive.
- ☐ VI. Black skin; rarely sun sensitive.

Are you of Asian heritage (Class V) and/or have a history of keloid scarring? ☐ Yes ☐ No

**TECHNICIAN:** _____

**PROCEDURE(s):** _____

**BENEFIT INTENDED** _____

I elect to receive the laser/light energy system procedure(s) indicated above for the stated benefit intended. I understand that outcomes may vary, including 1) good results in one session; 2) good results but only after additional sessions; 3) no results; and in rare cases 4) adverse results. I understand that other treatments to enhance outcomes may be recommended, including, but not limited to, the application of skin care products.

**Pre-Procedure and Aftercare Instructions:** I have received, and will strictly adhere to, all pre-procedure and aftercare instructions. I understand that for those with more color in the skin, it is advised to use a lightening agent leading up to the procedure to suppress the melanin in the skin. I understand there may be an extended period of recovery following the procedure(s), and that aftercare compliance is crucial for healing, prevention of scarring, hyper-pigmentation and hypo-pigmentation. I understand that particularly avoiding sun exposure after the procedure is crucial to reduce the risk of color change and will always apply a broad spectrum SPF 25 or higher, as recommended by my technician. I understand that initially, the skin treated may be red and swollen, that fine, thin scabs may form, and that the healing process typically takes anywhere from one to three weeks. However, I am aware that in rare cases, depending on my skin sensitivity and recovery capacity, healing could take as long as three to six months.

**Warning:** Treatment is not available to clients who are on **ACCUTANE and PHOTOSENSITIZING** medications. In addition, Clients using **ANTICOAGULANTS** must disclose this to the technician, as treatment may need to be modified to mitigate additional risk associated with the use of these drugs. For women of childbearing age: You confirm that you are not pregnant and do not intend to become pregnant during the course of treatment. Furthermore, you must keep your technician informed should you become pregnant during the course of treatment.

**Risks of Care:** I understand that the following problems may occur with treatment:

1. **Scarring:** This treatment can create a bruising and a moderate burn or blister to the skin. For an effective treatment, the power (joules) needs to be just below the blistering point which means skin will be red. There is a risk of scarring.

2. **Pigmentation:** The treated area may become either lighter (hypo-pigmented) or darker (hyper-pigmented) in color. This is rare and is usually just temporary, however may become permanent.

3. **Infection:** Although infection following this treatment is unusual, bacterial, fungal, and viral infections can occur. Herpes Simplex virus infections around the mouth can occur following a treatment, even if there is no past history of Herpes Simplex virus infections in the mouth area. Clients with a history of Herpes Simplex virus in the treated area are encouraged to seek preventative therapy. Should any type of skin infection occur, additional treatment, including antibiotics, may be necessary.

4. **Bleeding**: Pinpoint bleeding is rare but can occur following some laser treatment procedures. Should bleeding occur, additional treatment might be necessary.

5. **Skin tissue pathology:** Energy directed at skin lesions may potentially vaporize the lesion. Laboratory examination of the tissue specimen may not be possible. Only clearly benign pigmented lesions can be treated. A doctor's clearance should be obtained in the case of this type of treatment.

6. **Allergic reactions:** In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations, have been reported. Systemic reactions (which are more serious) may result from prescription medicines. Allergic reactions may require additional treatment. Due to skin surface disruption, irritation and histamine reactions may also occur resulting in itching, dermatitis, or other forms of sensitivity.

7. **Vision Damage:** I understand that exposure of the eyes to light during the procedure could damage vision. I will keep the proper eye protection on at all times.

I certify that this consent has been fully explained to me, that I have read the above paragraphs, and that I elect to receive the laser/light energy procedure(s) indicated above. I understand the various risks associated with the Procedure(s) and the importance of properly following pre-procedure and aftercare instructions to minimize those risks. I consent to my photograph being taken before and after the procedure(s).

**CLIENT / GUARDIAN SIGNATURE:** _____ **DATE:** _____

**TECHNICIAN SIGNATURE:** _____ **DATE:** _____

**NOTICE:** Occasionally, unforeseen problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.