ENDLESSBEAUTY
SKIN CARE
WHERE HEALTH AND BEAUTY BECOME ONE

CONSENT TO ADVANCED or CLASSIC ESTHETICS 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): This Informed Consent to Treat applies to two classifications of Esthetics care: Advanced Esthetics Services and Esthetic Classic Services. **Check the type of esthetic services below** applicable to you. Check both if you anticipate receiving treatment under both categories. Consult your technician if you have questions about the nature of treatment anticipated for you:

- ☐ **Advanced Esthetic Services:** Which includes Esthetic peels up to 40%, electrology, needling/collagen induction therapy, non-invasive ultrasound, and hand-held cryotherapy.
- ☐ **Esthetic Classic Services:** Which includes Body contouring, cellulite reduction, radio frequency, and high frequency treatments.

I elect to receive the esthetics procedure(s) indicated above. I declare that I am over the age of 18, not under the influence of drugs or alcohol, not pregnant or nursing, not on blood thinners or blood pressure medication, and am not an insulin-dependent Diabetic. I understand that if I am under the age of 18, Parental Consent is required for me to obtain these procedures. Under no circumstances may I have these services if I am under the age of 14. I represent that the stated date of birth is truthful on this form.

I understand that many medications and some diseases and disorders may either contraindicate me for treatment or affect the results. I understand I should continue taking my medications, and tell my technician about all prescription and non-prescription drugs, supplements, topically applied products, eye drops, etc. that I use or take. I understand that due to the nature of this treatment, results cannot be predicted, and I acknowledge that no guarantees have been made as to the results that may be obtained.

Warning: Treatment is not available to clients who are on *Accutane*. 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. Clients with a pacemaker, internal defibrillator, or metal implants must disclose this to the Technician as this may contraindicate them for treatment. 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.

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Bend, OR 97701

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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.

General Risks of Procedure(s): I understand there are risks associated with my procedure, including, but not limited to: minor burns, blistering, hypopigmentation (lightening of the area), hyperpigmentation (darkening of the area), swelling, allergic reactions, bruising, scarring, pin-point bleeding, pimple-like bumps, dry skin, tingling, and other similar side effects and/or reactions. I understand these risks also include, but are not limited to, the following:

1. **Scarring:** This treatment can create bruising and a moderate burn or blister to the skin. Depending on treatment received, more serious side effects may include, skin indentations or subcutaneous fat loss, and open sores that lead to infection.
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. **Skin tissue pathology:** Only clearly benign pigmented lesions can be treated. A doctor's clearance should be obtained in the case of this type of treatment. Treatment directed at abnormal lesions can cause malignant cells to develop and laboratory examination of the tissue specimen may not be possible.
5. **Allergic reactions:** Due to skin surface disruption, irritation and histamine reactions may occur resulting in itching, dermatitis, or other forms of sensitivity. In rare cases, local allergies to topical preparations have been reported.

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 advanced esthetic 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.

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.

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