Westchase Medspa
Where aging is optional

6928 W. Linebaugh Ave. Suit 102, Tampa, FL 33625
(813) 749-7143
(813) 264-9262
www.westchasespa.com

Informed Chemical Peel Consent

1. I authorize the chemical peel listed below, to my face and / or neck, chest and hands.
2. Depending on the chemical peel site, there may be redness and/or inflation and discoloration [dark tan and pink marks) that can persist for several days or weeks.
3. Occasionally hyperpigmentation or hypopigmentation might develop after the peel that might persist for weeks or months.
4. With each chemical peel/results are achieved. Nevertheless, no guarantees can be made as to the final results. Any number of chemical peels may be required to achieve desired results, depending on the present skin condition, skirt care maintenance program, age and lifestyle of the patient.
5. Once the desired results are achieved, I understand that maintenance peels are necessary to sustain the rejuvenating results. The frequency depends on the individual's own genetics, age and lifestyle.
6. Once peeling process is complete it is essential to follow instructions and/or use the designated skin care line, to maintain results and avoid any future complications particularly hyper pigmentation.
7. I understand that this peel is made of the strongest acids such as Phenol and Trichloroacetic add. also referred to as TCA, salicylic acid, among others. The exact composition is proprietary information of the Peel system, and I waive any rights present or future, I may have as to request to divulge the exact composition or concentrations.
8. Services are cosmetic in nature, and are non-refundable t understand that payment is my sole responsibility.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures I certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion and to ask questions.

Name/Type of Peel: ______________________________

(Print) Patient Name: ______________________________

Patient Signature: ______________________________

Witness Signature: ______________________________

Date: ____________________

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Confidential Patient Information

Name:______________________ Date of Birth:______________ Age:________ Sex: ☐ Male ☐ Female
Address:______________________ City:______________ State:____________ Zip:__________
Home phone:______________ Cell phone: ______________ Email Address:______________________

Please check if you are affected by or have any of the following:

☐ Asthma ☐ Fever Blister ☐ Hysterectomy ☐ Pacemaker
☐ Cardiac Problems D ☐ Headaches-chronic ☐ Immune Disorders ☐ Sinus Problems
☐ Depression/Anxiety ☐ Hepatitis ☐ Lupus ☐ Skin Diseases-other
☐ Eczema ☐ Herpes ☐ Metal bone ☐ Urinary or Kidney Problems
☐ Epilepsy ☐ High Blood Pressure ☐ Pins or plates

Are you... ☐ Pregnant? ☐ Trying to get Pregnant? ☐ Breastfeeding? ☐ Lactating?

Please choose the best match for yourself

What is your hereditary background? ______________________
Natural Eye Color:______________ Natural Hair Color:______________ Skin tone:______________

Do you consider your skin (Check all that apply):

☐ Normal ☐ Milia ☐ Eczema ☐ Patchy Dryness ☐ Breakouts
☐ Dry ☐ Cysts ☐ Freckled ☐ Sallow
☐ Dark Circles ☐ Acne-Scarred ☐ Melasma ☐ Psoriasis
☐ Oily ☐ Large Pores ☐ Hyperpigmentation ☐ Dehydrated/lacking Moisture
☐ Acne ☐ Small Pores ☐ Hypopigmentation ☐ Telangiectasia/broken Surface
☐ Comedones/blackheads ☐ Rosacea ☐ Uneven/blotchy ☐ Capillaries

Do you consider your skin: ☐ Sensitive ☐ Resilient ☐ Unsure

Do you have any allergies to medications? (Please list all allergies on back of page.)

Do you have allergies to cosmetics, foods, or drugs? ☐ Yes ☐ No
Do you have allergies to aspirin? ☐ Yes ☐ No
Do you use or receive depilatories or waxing? ☐ Yes ☐ No
Have you had collagen, Botox or other dermal filler injections? ☐ Yes ☐ No
Are you presently under a physician's care for any skin condition? ☐ Yes ☐ No

Have you had skin cancer? ☐ Yes ☐ No
Have you ever or are you now using Accutane? ☐ Yes ☐ No
Are you sensitive to alcohol based products? ☐ Yes ☐ No
Do you use sunscreen daily? ☐ Yes ☐ No
Are you taking birth control or hormone replacements? ☐ Yes ☐ No

If yes, please explain:______________________

Do you have sensitive to any of the following? ☐ Yes ☐ No
☐ Milk ☐ Apples ☐ Citrus ☐ Grapes ☐ Aloe vera ☐ Aspirin ☐ Perfumes ☐ Latex ☐ Hydroquinone ☐ Mushrooms

Do you experience cold sores/fever blisters? ☐ Yes ☐ No
Do you use tanning beds? ☐ Yes ☐ No
Have you recently had facial surgery? ☐ Yes ☐ No
If yes, what type of surgery?______________________
Have you recently had laser resurfacing? ☐ Yes ☐ No
If yes, what type of treatments and when?______________________

Do you smoke, use tobacco or live with a smoker? ☐ Yes ☐ No
Do you have permanent make-up? ☐ Yes ☐ No
Have you had professional skin care in the past? ☐ Yes ☐ No

Do you often experience stress? ☐ Yes ☐ No
Do you wear contact lenses? ☐ Yes ☐ No
Do you participate in vigorous exercise or sports? ☐ Yes ☐ No

What skin care products do you currently use? ______________________
How many ounces of water do you drink daily? ______________________

______________________ ______________
Signature Date

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Client Treatment Consent and Release

I acknowledge that beauty treatments, the practice of skin care, and the practice of massage, including, but not limited to, microablation, microdermabrasion, waxing, electrolysis, facial toning, permanent cosmetics, body treatments, ionization, laser treatments, tattoo removal, vein treatments, brown spot removal, BOTOX, Collagen, Dermal Fillers, Sclerotherapy, Mesotherapy, Dermaplaning, and various other beauty procedures is not an exact science and no specific guaranties can or have been made concerning the outcome. I understand that some clients experience more change and improvement than others. In virtually all cases, multiple treatments are required in order to realize a difference.

I also understand and agree to assume the following risks and hazards which may occur in connection with any particular treatment including but not limited to: unsatisfactory results, soreness, poor healing, discomfort, redness, blistering, nerve damage, scarring, infection, and change in skin pigmentation, allergic reaction, muscle damage, and increased hair growth. I understand that even though precautions may be taken in my treatment, not all risks can be known in advance.

Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. Therefore, in consideration for any treatment received, I agree to unconditionally defend, hold harmless and release from any and all liability the company and the individual that provided my treatment, the insured, and any additional insured's, as well as any officers, directors, or employees of the above companies for any condition or result, known or unknown, that may arise as a consequence of any treatment that I receive.

I have fully disclosed on my client intake form any medications, previous complications, or current conditions that may affect my treatment. I understand and agree that any legal action of any kind related to any treatment I receive will be limited to binding arbitration using a single arbitrator agreed to by both parties.

Date:________________________

Client Signature:______________________________ Printed Name:______________________________

Model Release

In consideration for treatment received, I hereby grant permission to the individual or company that provided my treatment to use any photographic treatment records for the purposes of clinical and statistical studies, advertising, or promotion without any additional compensation to me.

Date:________________________

Client Signature:______________________________ Printed Name:______________________________

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HIPAA Consent

I give Westchase Medspa my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care options like quality reviews. I give Westchase Medspa my consent to use or disclose my protected health information in order to obtain payment for services and/or product.

I have been informed that I may review Westchase Medspa's Notice Of Privacy Practices (for a more complete description on uses and disclosures) before signing this consent.

I understand that Westchase Medspa has the right to change their privacy practices and that I may obtain any revised notices at the clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Westchase Medspa is not required to agree to the request. If Westchase Medspa agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Patient, parent or legal guardian:____

Signature:____ Date:________________________

If signed by patient representative, state relationship to patient:____

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Face Treatment Form

Client's Name: ____

Date: ____________________ Technician: ____________________

Facial/body treatment type: ______________________________

Products used: ____

(Micro) tip(s) used: ____

Skin reactions: ____

Notes:

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Face Treatment Form

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Notes:

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Chemical Peel - Instructions

All of the Westchase Medspa's Signature Chemical Peels continue to provide benefit up to 4 or more hours following application of the products. For optimal results, leave the peel solution untouched until the next morning. The product will continue to work on correcting your skin during this time, so it is important not to wash, touch or apply makeup to treated areas for at least 4 hours following application. It is equally important to avoid sun exposure. During the first week of the peeling process you may experience sensitivity, so sun exposure should be limited and adequate protection provided with sunscreen.

Day 1 – Day of treatment

- Leave the treated area untouched until the morning following treatment.
- In the event you need to wash your face the first evening of treatment and have waited 4 hours following the peel application we recommend using the gentle cleansing gel recommended by your provider and water, pat dry and apply a thin layer of Rescue Intense Moisture Crème to the treated area.
- If needed, makeup can be applied over treated areas 4-6 hours post peel application.

Days 2-5

- Each morning, cleanse the treated area with the recommended gentle cleansing gel and pat dry. Do not rub the freshly treated areas.
- Prior to bedtime, wash your face with the recommended gentle cleansing gel and water, pat dry and apply a thin layer of Refine A to the treated area. **Discontinue use of Refine A after day 3.**
- If your skin feels dry, you may begin applying Rescue Intense Moisture Crème as needed (wait 10 minutes prior to application following Refine A).
- The natural peeling process typically begins typically by day 3. Most patients notice a slight sloughing of the skin around their perioral area (mouth) followed by the remaining treated areas. (If needed, the neck, chest, back and hands will take slightly longer to start the peeling process…up to a week).
- After the peeling process begins, apply Rescue Intense Moisture Crème as needed for comfort and additional moisture. **IMPORTANT: Refrain from picking the sloughing skin to avoid redness, irritation and hyperpigmentation during the peeling process.**
- Gently wash treated areas morning and night. Old skin will slough off. Pat dry (do not scrub). Apply Rescue Intense Moisture Crème after washing.

Day 6 and After

You may resume your prescribed skin care regimen for optimum results. If your skin is still sensitive, red or irritated, wait until sensitivity subsides before resuming your pre-peel regimen. Apply Enzyme Infusion Peel to moist, clean skin for 20 minutes; wash off with warm water on days 8 and 10 to remove any remaining peeling skin for a fresh look.

During the time before and after peeling process begins, do not excessively soak treated areas. This will cause the skin to prematurely peel, causing redness and irritation.

Avoid sunlight as much as possible during the peeling phase. Apply Sunscreen with a physical sunblock when exposing treated areas to the sun.

Do not have facial treatments, of any kind (facials, microdermabrasion, waxing, laser, etc.) for at least 1 week after you have completely finished peeling. Do not use anything on your face other than your recommended skin care products. Other products may contain unknown ingredients that could cause stinging and burning, or irritation. If you do, wash it off with the recommended gentle cleansing gel immediately.

It will take your skin approximately 4 days after the completion of your peeling to go back to its normal pH balance. This is when your skin will start to look its best.

At this time you may resume use of your prescribed skin care products, including any pigment reducing complexes as instructed by your provider.

The skin's sensitivity to the sun is greatly increased after the chemical peel, proper sun protection is required.

Follow Up:

The chemical peel can be applied every four to six weeks until desired results are achieved. Results are cumulative and maximum benefits are seen with a series of three or more peels. Once the series is complete and maximum benefit has been achieved, repeat peels are recommended every 8 to 12 weeks to maintain healthy, youthful skin.

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