

## Microdermabrasion Client Informed Consent Form

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

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

This consent form is designed to verify that you have been satisfactorily informed and educated in respect to your microdermabrasion skin care treatment, as well as its aftercare, so that you may make an educated decision as to whether to have this procedure performed. This disclosure is not meant to alarm you; it is simply an effort to make you better informed so you may give, or withhold, your consent for treatment. Please read and initial where indicated.

1. I acknowledge having been informed that this cosmetic procedure is intended to remove superficial surface layers of the skin to improve the vitality of the skin. **Initial here:** \_\_\_\_\_
2. I have not had used Glycolic, AHA or Retinol products for at least 7 days prior to treatment and further acknowledge that I will not use these products for at least 7 days post treatment. **Initial here:** \_\_\_\_\_
3. I understand that my skin care professional can discover other, or different conditions that may require additional or different procedures than those planned. If my skin care professional discovers such other or different conditions I will be referred to an appropriate medical care provider. **Initial here:** \_\_\_\_\_
4. It has been explained to me that because microdermabrasion procedures are a superficial abrasion to the skin, the result of a one-time treatment is similar to a deep cleansing or polishing of the skin. I understand that in order to see significant results these treatments need to be done in a series and in combination with active ingredient skin care products. **Initial here:** \_\_\_\_\_
5. I acknowledge that while the goal of such a procedure is the removal of damaged skin, the realistic results average at least fifty percent improvement. I acknowledge that the practice of cosmetology is not an exact science and that no specific guarantees can or have been made concerning the expected result. Some clients' skin may show improvement, while others may not show marked improvement. **Initial here:** \_\_\_\_\_
6. I acknowledge that after my microdermabrasion procedure, all treated areas may feel warm and appear sunburned or my skin may experience a wind-burned sensation. **Initial here:** \_\_\_\_\_
7. I understand that my compliance to my aftercare instructions will greatly affect my final result. I acknowledge my obligation to follow the written and spoken instructions covering my pre- and post-treatment skin care regimen. **Initial here:** \_\_\_\_\_
8. I understand that although rare, certain risks or complications could occur but are usually treatable and temporary, such as hyper-pigmentation, hypo-pigmentation, and scarring. Following all post procedure instructions will help avoid conditions. **Initial here:** \_\_\_\_\_
9. I acknowledge that if I am prone to Herpes (cold sores, fever blisters) that I may need a prescription for Valtrex (acyclovir) prior to having microdermabrasion. I need to avoid treatments during a breakout. **Initial here:** \_\_\_\_\_
10. I acknowledge that I have not used Accutane during the last six months. **Initial here:** \_\_\_\_\_
11. Acne patients, it has been explained to me that I may experience a slight acne flare-up, and that my acne condition may temporarily look worse for a few days after a microdermabrasion treatment. **Initial here:** \_\_\_\_\_
12. I acknowledge that I have been instructed to avoid sun exposure and must wear a sun block of at least SPF 25 over the treated areas on a daily basis during my treatment series. **Initial here:** \_\_\_\_\_
13. I understand that if I have any additional questions or concerns that I should call the office immediately. **Initial here:** \_\_\_\_\_

I have read and initialed each paragraph and have been satisfactorily informed of the benefits, risks, and complications regarding microdermabrasion. I consent to this microdermabrasion treatment today and for all subsequent microdermabrasion treatments.

Patient Signature: \_\_\_\_\_

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

Witness Signature: \_\_\_\_\_

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

Parent/Legal Guardian Signature (if patient is a minor): \_\_\_\_\_

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

## Confidential Patient Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Homephone: \_\_\_\_\_ Cellphone: \_\_\_\_\_ Email Address: \_\_\_\_\_

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

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Fever Blister       | <input type="checkbox"/> Hysterectomy     | <input type="checkbox"/> Pacemaker                  |
| <input type="checkbox"/> Cardiac Problems D | <input type="checkbox"/> Headaches-chronic   | <input type="checkbox"/> Immune Disorders | <input type="checkbox"/> Sinus Problems             |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Lupus            | <input type="checkbox"/> Skin Diseases-other        |
| <input type="checkbox"/> Eczema             | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Metal bone       | <input type="checkbox"/> Urinary or Kidney Problems |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> 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):**

- |   |                                       |  |  |                                    |
|---|---------------------------------------|--|--|------------------------------------|
| <input type="checkbox"/> Normal               | <input type="checkbox"/> Milia        | <input type="checkbox"/> Eczema            | <input type="checkbox"/> Patchy Dryness                | <input type="checkbox"/> Breakouts |
| <input type="checkbox"/> Dry                  | <input type="checkbox"/> Cysts        | <input type="checkbox"/> Freckled          | <input type="checkbox"/> Sallow                        |                                    |
| <input type="checkbox"/> Dark Circles         | <input type="checkbox"/> Acne-Scarred | <input type="checkbox"/> Melasma           | <input type="checkbox"/> Psoriasis                     |                                    |
| <input type="checkbox"/> Oily                 | <input type="checkbox"/> Large Pores  | <input type="checkbox"/> Hyperpigmentation | <input type="checkbox"/> Dehydrated/lacking Moisture   |                                    |
| <input type="checkbox"/> Acne                 | <input type="checkbox"/> Small Pores  | <input type="checkbox"/> Hypopigmentation  | <input type="checkbox"/> Telangiectasia/broken Surface |                                    |
| <input type="checkbox"/> Comedones/blackheads | <input type="checkbox"/> Rosacea      | <input type="checkbox"/> Uneven/blotchy    | <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No               | Have you had skin cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No                             |
| Do you have allergies to aspirin? <input type="checkbox"/> Yes <input type="checkbox"/> No                                  | Have you ever or are you now using Accutane? <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| Do you use or receive depilatories or waxing? <input type="checkbox"/> Yes <input type="checkbox"/> No                      | Are you sensitive to alcohol based products? <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| Have you had collagen, Botox or other dermal filler injections? <input type="checkbox"/> Yes <input type="checkbox"/> No    | Do you use sunscreen daily? <input type="checkbox"/> Yes <input type="checkbox"/> No                           |
| Are you presently under a physician's care for any skin condition? <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you taking birth control or hormone replacements? <input type="checkbox"/> Yes <input type="checkbox"/> No |

If yes, please explain: \_\_\_\_\_

- Do you have sensitive to any of the following?  Yes  No
- |                               |                                 |                                 |                                 |                                    |                                  |                                   |                                |                                       |                                    |
|-------------------------------|---------------------------------|---------------------------------|---------------------------------|------------------------------------|----------------------------------|-----------------------------------|--------------------------------|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Milk | <input type="checkbox"/> Apples | <input type="checkbox"/> Citrus | <input type="checkbox"/> Grapes | <input type="checkbox"/> Aloe vera | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Perfumes | <input type="checkbox"/> Latex | <input type="checkbox"/> Hydroquinone | <input type="checkbox"/> 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 often experience stress?  Yes  No

Do you have permanent make-up?  Yes  No

Do you wear contact lenses?  Yes  No

Have you had professional skin care in the past?  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 \_\_\_\_\_



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

## 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: \_\_\_\_\_

## Face Treatment Form

Client's Name: \_\_\_\_\_

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

Facial/body treatment type: \_\_\_\_\_

Products used: \_\_\_\_\_

(Micro) tip(s) used: \_\_\_\_\_

Skin reactions: \_\_\_\_\_

Notes:  
\_\_\_\_\_



## Face Treatment Form

Client's Name: \_\_\_\_\_

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

Facial/body treatment type: \_\_\_\_\_

Products used: \_\_\_\_\_

(Micro) tip(s) used: \_\_\_\_\_

Skin reactions: \_\_\_\_\_

Notes:

Client's Name: \_\_\_\_\_

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

Facial/body treatment type: \_\_\_\_\_

Products used: \_\_\_\_\_

(Micro) tip(s) used: \_\_\_\_\_

Skin reactions: \_\_\_\_\_

Notes:

Client's Name: \_\_\_\_\_

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

Facial/body treatment type: \_\_\_\_\_

Products used: \_\_\_\_\_

(Micro) tip(s) used: \_\_\_\_\_

Skin reactions: \_\_\_\_\_

Notes: