Hair To Bare South

Client Name: _____ Date: _____

I authorize Rachelle Stokes (Hair To Bare South) to perform the treatments. The purpose of these treatments is to diminish or remove unwanted hair. The quantity of hair that will disappear will depend on the client's skin type, hair color, hair thickness, region to be treated, energy level or tolerance to pain, and hormonal level. The treatment plan requires more than one treatment and may produce permanent hair removal. The average loss of hair is 80% to 100%. A residue of hair may remain at the end of the treatment. Residual hair is typically 50% lighter and thinner. The total number of treatments will vary between individuals. On occasion, there are clients that do not respond to treatments. The treated hair should exfoliate or push out in approximately 2-3 weeks.

Treatment Sites: mono-bow, lip, chip, neck, face arms, fingers, chest, areola, linea, underarms, back buttocks, bikini, labia, scrotum, thighs, lower legs feet, toes.

Alternate methods are waxing, shaving, electrolysis and chemical epilation.

We are unable to treat clients that are on ACCUTANE, RETINA, RETINOL and PHOTOSENSITIZING (Sun sensitive) medications. If you are using any of the above you must wait 4 weeks after stopping before laser hair removal treatments can be done.

Clients using ANTICOGULANTS should be noted.

The following problems may occur with the hair removal treatment:

1. *Tattoo Removal:* If you have had tattoo removal anywhere on your body and do not inform the technician of this, blistering and infection can occur if the laser is applied to this area. It is very important to inform the technician each visit to ensure your safety.

2. *Scarring:* THE IPL system can create a bruising and a moderate burn or blister to the skin. For an efficient treatment, the power (joules) needs to be just below the blistering point, which means skin will be red, However slight, there is risk of scarring.

3. *Hyperpigmentation* (browning of the skin) and *Hypopigmentation* (whitening of the skin) have been noted after treatment, especially with a darker complexion. This usually resolves within weeks but it can take as long as 3-6 months in some cases. Permanent color change is a rare risk. If you have a lot of color in your skin, a skin lightening cream will be advised to reduce the melanin in your skin before the treatment. Avoiding sun exposure after the treatment is crucial to reduce the risk of color change.

4. *Erythema* (redness) and *Edema* (swelling) of the treated area may occur. Although this usually subsides within a few hours, it can last up to 7 days or longer. Irritation, itching, and /or mild burning sensation may or pain similar to a sun burn may occur within 48 hours of treatment.

5. *Infection:* Although infection following IPL treatment is unusual, bacterial, fungal and viral infections can occur. Herpes virus infection around the mouth and/or genitals can occur following an IPL treatment. This applies to individuals with a herpes virus infection. Should any type of infection occur, additional treatment, including antibiotics, might be necessary*. If you have a history of the herpes virus in the treated area we recommend preventive therapy.*

6. *Bleeding:* Pinpoint bleeding is rare but can occur following age/ sun spot and spider vein treatment procedures. Should bleeding occur, additional treatment might be necessary.

7. *Skin Tissue Pathology :* Energy directed at skin legions may potentially vaporize the lesion. Laboratory examination of the tissue specimen may not be possible. *Only clearly benign pigmented lesions can be treated. Check with your doctor for clearance.*

8. *Allergic Reactions*: In rare cases, local allergies to tape or preservatives used in preparations have been reported. Systemic reactions (which are more serious) may result from prescription medicines. Allergic Reactions may require additional treatment.

9. *Photosensitive (sun sensitive) Medication*: You understand that if you are taking a medication that makes your skin sensitive to the sun, you are responsible to note these medication (s) and to inform the technician and wait at least 4 weeks before treatment can be done.

10. *Ingrown Hair(s):* I understand that if I do not exfoliate and extract ingrown hairs frequently after laser hair removal that the ingrown hair(s) can become damaged by laser hair removal and become infected or abscessed. This is caused because the ingrown hair cannot push itself outside of the body.

11. *Wear Sunscreen of SPF 25 or higher before and after treatment to protect your skin.*

12. *I understand that I may need multiple treatments for the desired outcome.*

13. *I understand the exposure of my eyes to light could harm my vision. I will keep the eye protection on at all times.*

14. *I have read and understand the Pre and Post Treatment instructions*. I agree to follow these instructions carefully. I understand that compliance with recommended Pre and Post Treatment guidelines is crucial for healing, preventing of scarring, hyperpigmentation, hypopigmentation, and other skin textural changes.

15. *I understand that the treatments may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks.* I have been informed of other treatment options and understand that I have the right to refuse treatment. With this in mind, I am choosing this non-invasive treatment for hair removal.

16. *No guarantee, warranty, or assurance has been made to me as to the results that may be obtained.* I am aware that follow up treatments are necessary for desired results. I understand that gradual results occur over several treatments.

17. *I understand that all services rendered to me are charged directly to me and that I am personally responsible for payment.*

ACKNOWLEDGEMENT

The nature and purpose of treatment has been explained to me. I have read and understand this agreement. All of my questions regarding the treatment have been answered satisfactorily. I understand the treatment and accept the risks.

I consent to terms of this agreement. I certify that I am competent adult of at least 18 years of age. This informed consent form is freely and voluntarily executed and shall be binding upon me. I hereby release Rachelle Stokes and The New You Skin Therapy from all liabilities associated with the above indicated treatment.

Client Printed Name: _____ Client Signature: _____ Date: _____

Guardian Printed Name: _____ Minor Treated: _____

Guardian Signature: _____ Date: _____

Hair To Bare South

In order to provide you with the most appropriate Laser Hair Removal treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL DATA

Client Name: _____ Today's Date**:**_____

Date of Birth: _____ Age _____ Occupation _____

Home Address: _____ City _____ State _____ Zip _____

Cell Phone _____ Email: _____

Is it OK to mail and/or email promotions: Yes ☐ No ☐

Emergency Contact Name _____ Phone _____ Relationship _____

How were you referred to us: _____

Which of the following best describes your skin type? Please circle one type number.

I. Always Burn, Never Tans
II. Always burns, Sometime Tans
III. Sometime Burns, Always Tans
IV. Rarely Burns, Always Tans
V. Brown to Dark Brown, moderately pigmented skin
VI. Dark Brown to Brownish Black Skin

MEDICAL HISTORY

Have you ever had "Tattoo Removal"? Yes ☐ No ☐
If Yes, Where: _____

Are you currently the care of a physician Yes ☐ No ☐
If yes, for what? _____

Are you currently during the care of dermatologist Yes ☐ No ☐
If Yes, for What? _____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? Yes ☐ No ☐

Do you have any of the following medical conditions? Please check all that apply

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Herpes ☐ Arthritis ☐ Frequent Cold Sores

☐ HIV/Aids ☐ Keloid Scarring ☐ Skin Disease/skin lesions ☐ Seizure Disorder ☐ Hepatitis

☐ Hormone Imbalance ☐ Thyroid Imbalance ☐ Blood Clotting Abnormalities ☐ Any Active infection

☐ Acne ☐ Botox ☐ Hemorrhoids ☐ Polycystic Ovary Disease ☐ Heart Disease ☐ Burns/Skin Grafts

Do you have any other health problems or medical conditions? _____

_____

Have you ever had an allergic reaction to any of the following: Please check all that apply, describe the reaction you experienced: ☐ Food ☐ Latex ☐ Aspirin ☐ Lidocaine ☐ Hydrocortisone ☐ Hydroquinone or skin bleaching agents

Other Describe: _____

MEDICATION

What oral medications are you currently taking? ☐ Birth Control Pills ☐ Hormones

☐ Others Please list: _____

Have you ever used Accutane Yes ☐ No ☐ If yes when did you last use it? _____

What topical medications or creams are you currently using? ☐ RetinA ☐ Accutane ☐ Retinal ☐ Differin

Others Please list: _____

What herbal or vitamin supplements do you take regularly? _____

SUN, SKIN AND HAIR REMOVAL HISTORY

Have you ever had laser hair removal? Yes ☐ No ☐ If Yes, Where ? _____

Have you ever had an IPL hair removal? Yes ☐ No ☐ If Yes, How long Ago? _____

Have you used any of the hair removal methods in the past six weeks? Please check all that apply:

☐ Shaving ☐ Waxing ☐ Electrolysis ☐ Plucking/Tweezing ☐ Stringing ☐ Depilatories ☐ Threading

Are there any moles with hair in the area to be treated? Yes ☐ No ☐

Have you had any recent tanning or sun exposure that changed the color of your skin? Yes ☐ No ☐ If YES we recommend waiting 4 weeks

Have you recently used any self-tanning lotions or treatments? Yes ☐ No ☐ If yes we recommend waiting 2 weeks

Do you form thick or raised scars from cuts or burns? Yes ☐ No ☐

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 _____

Do you get ingrown hairs frequently? Yes ☐ No ☐ If Yes, It is very important to exfoliate as much as possible after laser hair removal treatment to prevent more ingrown hairs. Tweeze (remove) any ingrown hairs to prevent any adverse effects in the case that the ingrown hair is damaged by laser hair removal and is unable to push itself out.

FOR FEMALE CLIENTS

Are you pregnant or trying to become pregnant? Yes ☐ No ☐

Are you breastfeeding? Yes ☐ No ☐

Are you using hormone contraception? Yes ☐ No ☐

Are you currently going through menopause? Yes ☐ No ☐

I certify that the following preceding data, medical history, medication and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician of my current medical or health conditions and to update this history upon every treatment. A current medical history is essential for the technician to execute appropriate treatment procedures.

Printed Name: _____ Signature: _____ Date: _____

Guardian Name: _____ Signature: _____ Date: _____