Luxury Laser

MODERN HAIR REMOVAL

Patient Medical History

Laser Hair Removal

Name_____ DOB ___/___/___ Age: ____

Address _____

City _____ State _____ Zip _____

Phone_____ Email _____

How did you hear about Luxury Laser LLC ? _____

Area to be treated _____

Medical History Please circle any of the following that you currently have or to which you are susceptible (if none write "none"):

Histamine (hives reaction)	Cold sores	Heart condition
Latex Allergies	Cancer	Cryogen allergy
Diabetes	Hearing Aid	Hemophilia
Leukemia	Polycystic Ovaries	Herpes/ Cold sores
Thyroid	Keloids	Any blood disease
High Blood Pressure	Pregnant	Skin Cancer
Asthma	Acne	Epilepsy
Bruise Easily	Eczema	Hepatitis

Moles	Canker sores	Genital Herpes
Aids		

Tanning/ Sun Exposure 1 – 2 – 3 – 4 – 5

Allergies yes / no (if yes please specify) _____
Present Illness _____

Present Medications: Accutane, Aspirin, Antibiotics, Cortisone, Photosensitive such hormones, St. John's wort, Oral, Contraceptive, others _____

Date:_____

Fitzpatrick Skin Type Evaluation form

Your skin type, together with your hair and eye coloring is determined genetically.

The way skin responds to exposure to the sun is also a good indicator of skin type.

A common method of categorizing skin type used in the medical & esthetic fields is the *Fitzpatrick Skin Type Scale*. This is a major factor in determining the best course of laser hair removal treatment for you. To help us correctly classify your skin type, please fill up the following questionnaire by **circling the option that is most closely applies to you, in each case.**

Genetic Disposition

	0	1	2	3	4	score
Eye Color	Light blue, Light gray, Light green	Blue, Gray, Green	Brown, Hazel	Dark brown	Brownish black	
Natural hair color	Sandy, Red	Blond	Chestnut, Dark Blond	Dark brown	Black	
Color of unexposed skin	Reddish	Very Pale	Pale with beige tint	Light brown	Dark brown	
Freckles on unexposed areas	Many	Several	Few	Incidental	None	
					Total	

Reaction to Sun Exposure

	0	1	2	3	4	score

what happens when you stay too long in the sun	Pain, Redness, Blistering and peeling	Blistering followed by peeling	Sometimes burn, followed by peeling	Rarely burn	Never burn	
To what degree do you turn brown	Hardly, or not at all	Light tan	Reasonable tan	Tan very easily	Quickly turn dark brown	
Do you turn brown within just a few hours?	Never	Seldom	Sometimes	Often	Always	
How does your face react to sun	Very sensitive	Sensitive	Normal	Very resistant	Never have a problem	
					Total	

Please complete and sign overleaf →

Tanning Habits

	0	**1**	**2**	**3**	**4**	**score**
When did you last expose your body to sun, tanning booth/ cream?	More than three months ago	Two to three months ago	One to two months ago	Less than one month ago	Less than two weeks ago	
During those times, did you expose the area to be treated	Never	Hardly ever	Occasionally	often	Always	
					Total	

Score for Genetic Disposition: _____

Score for Reaction to sun Exposure: _____

Subtotal: _____

Score for Tanning Habits: _____

Grand Total (with tan): _____

Your Fitzpatrick Skin Type:

Skin Type Score	Fitzpatrick Skin Type
0 to 7	I
8 to 16	II

17 to 25	III
25 to 30	IV
More than 30	V or VI

I understand that recent tanning, by whatever method, can have a major impact on how my skin will react to laser hair removal treatment. It can cause hyper-pigmentation (darkening of the skin) or hypo-pigmentation (lightening of the skin), which may last for several months. In some cases it could also cause blistering which, if not properly cared for, could lead to scarring.

Name: _____

Signature: _____

Date: _____

Depression medication or mood altering drugs yes/ no _____

Hair type/ color (please circle) Coarse/ Average/ Fine/ Black/ Brown/ Light br/ Blond/ Red/ Gray

Skin Type: Light, Medium, Tan, Dark/ Olive, Brown

Caucasian, Hispanic, Indain, Mediterranean, African American,

Other: _____

I agree that the information listed above has been reviewed and presented with my clear understanding, of what this procedure involves.

I the undersigned declare that I have answered all the above questions to the best of my ability and knowledge.

I agree that the information listed above has been reviewed and presented with my clear understanding of what this procedure involves.

I will not hold my CCE, CME or Physician or any member of her/ his staff responsible for any errors or omissions that I may have made in the completion of this form. With full and clear understanding I release the technician from liability associated with these procedures.

Client Signature: _____ **Date:** _____

Informed Consent for Hair Removal

The purpose of this procedure is to diminish or remove unwanted hair. The procedure requires more than one treatment and may produce permanent hair removal. The total number of treatments will vary between individuals. **On occasion there are patients that do not respond to treatments.** The treated hair should exfoliate or push out in approximately 2-3 weeks. The following problems may occur with the hair system.

1. **However slight, there is a risk of scarring.**
2. **Short term effects may include reddening, mild burning and temporary bruising or blistering**. **Hyper-pigmentation** (browning) and **Hypo-pigmentation** (lightening) have also been noted after treatment. These conditions usually resolve within 3-6 months, but **permanent color change** is a **rare risk.** Avoiding sun exposure before and after the treatment reduces the risk of color change.

3. **Infection:** Although infection following treatment is unusual, bacterial, fungal and viral infections can occur. **Herpes** simplex virus infections around the mouth can occur following a treatment. This applies to both individuals with a past history of herpes simplex virus infections and individuals with no known history of herpes simplex virus infections in the mouth area. Should any type of skin infection occur, additional treatments or medical antibiotics might be necessary.

4. **Bleeding: for electrolysis only** pinpoint bleeding is rare but can occur following treatment procedures. Should bleeding occur, additional treatment might be necessary.

5. **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.

6. I understand that exposure of my eyes to light could harm my vision. **I must keep the eye protection goggles on at all times.**

7. **Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, and hyper-pigmentation.**

Occasionally, **unforeseen mechanical 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.

Acknowledgment:

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release Luxury Laser LLC from all liabilities associated with the above- indicated procedure.

Customer's Name: _____

Date: _____Signature: _____

Health Insurance Portability and Accountability Act (HIPPA) Consent

I consent to use or disclosure of my Protected Health Information (PHI) by **Luxury Laser LLC.** for the purpose of Treatment, Payment and Health care Operations. I have received a copy of the notice of privacy practices and understand I have a right to review prior to signing this document.

I Understand:

- Service to me may be conditioned upon my consent as evidenced by signature on this document.
- I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or health care operations of the practice. Luxury Laser LLC. is not required to agree to the restrictions that I may request. However, if Luxury Laser LLC agrees to a restriction that I request, the restriction is bringing on Luxury Laser LLC.
- I have the right to revoke this consent, in writing, at any time, except that Luxury Laser LLC has taken action in reliance on this consent.
- My PHI means health information, including my demographic information, collected from me and created or received by my physician, another care provider, a health plan, and a health care clearing house. This a reasonable basis to believe the information may identify me.
- I may request a copy of my medical records for the current charge for copying.

The Notice of Privacy Practices Describes:

- The types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations performed by Luxury Laser LLC.
- My rights and the duties of Luxury Laser LLC with respect to me PHI.

Luxury Laser LLC reserves the right to change its privacy practices. All current or revised notices can be obtained on our e-mail at info@luxurylaser.com or contact our office (727)-789-5711 and requesting a copy to be mailed, or coming by the office at 35080 US Hwy 19 N, Palm Harbor, FL 34684.

Address:_____ City:_____ Zip:_____

Signature of Patient:_____ Date:_____

Print Patient Name:_____

Treatment includes activities performed by a health care provider, nurse, office staff and other types of health care professionals providing care providers. Payment includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization. Health Care Operations includes the necessary administrative and business functions of our office PT accepted/ declined copy of this document.

Liability Release Form and Refund Policy

Luxury Laser LLC provides each client with information regarding treatment procedures as well as pre and post care treatment to achieve the best results possible. Luxury Laser LLC requires a consultation with each client and the CME or Medical Director before treatments can begin.

All clients MUST sign a consent form indicating that they have read all the pre and post treatment instructions, which are also discussed during consultation.

The consent form is an agreement with the client that he/she is agreeing to be treated and that the client fully understands all of the pre and post treatment instructions as well as possible symptoms or side effects and skin reactions that may occur due to treatment. These symptoms and side effects include: scarring, reddening, mild burning, temporary bruising or blistering, hyper pigmentation (browning increased pigment of skin) or hypopigmentation (lightening of the skin), infection, bleeding, allergic reactions, and impaired vision (if goggles are not worn during treatment). These symptoms and side effects are normal and cannot be predicted. All side effects vary with each individual and are NOT PERMANENT.

If any of the above should occur the following measures should be taken:

1. Inform a representative at Luxury Laser LLC immediately. If immediate care is needed a physician will evaluate the patient and necessary treatment will be provided.
2. Fill out a form describing in full detail what types o symptoms or side effects are present. This will be done in ALL cases that have any type of symptoms or side effects.
3. Mail the form to the address provided on form and wait to be contacted in reference to necessary required or to resolve any concerns regarding treatment.

4. All treatments will stop until all issues are resolved.
5. The patient will be reassessed before further treatments will be provided.

If it is decided by the physician at Luxury Laser LLC that the client cannot continue treatments a full refund will be provided. However, if the client chooses not to continue treatments due to other reasons or the client is not satisfied with his/her treatments, the client is not entitled to a full refund. If this should occur, the client MUST explain the reasons why he/she does not want to continue their treatments they MUST complete the required forms to file a complaint. Each case will be evaluated and addressed individually. In cases that a client buys a package and never starts treatment, 90% of the price will be refunded.

By signing this form, you are giving Luxury Laser LLC Inc, permission to treat you, and you understand all symptoms and side effects that may occur during or after treatments, thereby releasing Luxury Laser LLC Inc. of all liability regarding these issues.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Pre-Treatment

1. SHAVE treated area as we want to direct the laser energy in to the hair follicle.
2. NO SUN or TANNING exposure 2 weeks prior to treatment. Always use sun block of SPF 45 or higher.
3. DO NOT pluck, wax or tweeze during the time of laser treatments.
4. NO Retin-A, Tetracycline, Accutane when treating facial area.
5. Patients with a history of herpes simplex 1 or 2, cold sores or any variation of these should be put on oral antiviral drugs (Zovirax or Famvir) beginning a day or two before treatment.
6. NO ANTIBIOTICS or any photosensitive medications during the time of treatment.
7. At the time of treatment, laser protective glasses MUST be worn.
8. If consuming any hormone stimulating or anti-depression medication, client MUST notify us.

Post Treatment

1. NO SUN or TANNING exposure 2 weeks after treatment. Change of pigmentation in the treated area will appear with combination of laser and sunlight. Always use a sunblock of SPF 45 and higher.
2. Extra hygiene care at home required.
3. DO NOT pluck, wax or tweeze during the time of laser treatment.
4. Redness and swelling of follicles/tissue may appear after treatment. This will usually stay 15-20 minutes and up to a couple of days in very sensitive skin.

5. To reduce swelling use an ice pack. If scabbing, pustules or follicle inflammation appears, apply Hydrocortisone 1% or an antibiotic cream such as Neosporin, Polypore and Bactrian for 2-3 days after the treatment.
6. DO NOT PICK SCABS for proper healing of the skin.
7. When treating facial area if make-up is necessary it MUST be fresh and can be used day after the treatment to minimize risk of irritation.
8. DO NOT TOUCH, RUB, SCRATCH or PICK treated area.
9. Within a few days after the treatment, stubbles representing dead hair follicles will appear. Complete exfoliation will take from 10-20 days.

Should you have any concerns or questions, please do not hesitate to call to the office. Our main goal is client satisfaction. That is why it's VERY important to educate our client, so they will fully understand the procedure of Laser Hair Removal/Reduction and have trust, confidence cooperation in their decision.

Signature: _____ Date: _____

We guarantee our complete confidentiality, care and understanding. A member of the Society provides this guide to you for Clinical and Medical Hair Removal.

Client Treatment Consent and Release

I acknowledge that beauty treatments, the practice of skin care, including but not limited to, laser treatments, electrolysis hair removal, 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,

change in skin pigmentation, allergic reaction, muscle damage and increased hair growth. I understand that even though precautions may be taken in my treatments, 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 insureds, as well as any 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 from any medications, previous complications, 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.

We at Luxury Laser LLC serve the right to make changes in our prices at any given time with no further notice.

Client Signature

_____

Print Name

_____

Date:_____

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 and statistical studies, advertising or promotion without any additional compensation to me.

Client Signature_____

Print Name _____

Date:_____

To our valued clients,

We at Luxury Laser LLC appreciate your business.

Please be on time for your appointment and notify us 24 hours in advance if you need to change your appointment time.

Same day cancelations will be charged a $25 cancelation fee.

Payments made to Luxury Laser LLC will not be refundable. No refunds will be given for services or products that have been purchased. Spa credit may be issued in some cases at the discretion of Luxury Laser LLC.

Date: _____

Signature: _____