PLASMA PEN/FIBROBLASTING CONSENT FORM

NAME : _____
CONTACT NUMBER/CELL PHONE : _____
EMAIL : _____
DOB : _____
TREATMENT AREA : _____

Some medical conditions may be contraindication to receiving the procedure, so it is important you provide the information below. It is ultimately your responsibility to ensure that you understand in full the fibroblasting procedure and the expected outcomes before your treatment commences.

Please circle any of the following contraindications that pertain to you.

❐ Cold Sores ❐Herpes ❐Shingles ❐Botox/Fillers within past 21 days ❐Cosmetic Surgery in past year ❐Pregnant/Breast Feeding ❐Cancer ❐Chemotherapy/Radiation ❐Keloids ❐Hyperpigmentation ❐Cataracts/glaucoma ❐Frequent Eye Infections ❐Contact Lenses ❐Laser Eye Surgery ❐Diabetes ❐Hemophilia or any other blood disorder ❐ Blood Thinners

If you circled any of the above, please explain :
_____
_____
_____

Please initial each paragraph and check yes or no after reading.

____ I understand post-treatment I may not look my best for the next few days and may potentially experience some minor discomfort, redness and swelling? ❐Y ❐N

____ Do you have any allergies or have you ever experienced allergic reactions to any kinds of medications, foods or products (for example latex gloves)? ❐Y ❐N

____ Do you or have you ever suffered an allergic reaction to any local/topical anesthetics? ❐Y ❐N

____Are you currently undergoing any medical treatment and/or have you received any medical treatment within the last 6 months? ❐Y ❐N

____Are you currently taking any medication. This includes any over the counter remedies? ❐Y ❐N

____Do you knowingly have an infectious disease or other acute or chronic disease? ❐Y ❐N

____ Do you suffer from uncontrolled, high or low blood pressure or any other kind of circulatory issues or defi ciencies? ❐Y ❐N

____ Do you suffer from dizziness, fainting attacks or any other seizure related condition? ❐Y ❐N

____Do you have any history of cancer? If yes, have you had any radiation or chemotherapy treatment? ❐Y ❐N

____ Do you currently have or have you ever been treated for any pigmentation disorders such as Melasma, Age Spots, Hyperpigmentation, Vitiligo and Solar Lentigines etc.? Do you ever develop dark spots on the skin from wounds? ❐Y ❐N

____ Are you taking or have you applied any oral/topical steroids or corticosteroids in the last 6 months? This would include Hydrocortisone for Eczema. ❑Y ❑N

____Do you suffer from, or have any problems with scars healing? Do you suffer from keloid scarring, hypertrophic scarring or any other type of scarring? ❑Y ❑N

____ Do you regularly use Retinol, Glycol, Salicylic Acid or benzoyl peroxide or any other exfoliating products devices (Clarisonic)? ❑Y ❑N

____ Have you ever had any recent Permanent Make Up (PMU) or cosmetic treatment? If so when and did you experience any problems healing? ❑Y ❑N

____ Do you have any corneal abrasion or retinal detachment? ❑Y ❑N

____Do you have any prosthetic implants or any plates or pins in the area being treated by Plasma Pen? ❑Y ❑N

If you answered yes to any of the above, please explain: _____
_____

Is there any other ailment or reason not listed above you feel we should know about which could prevent us from delivering your Plasma Pen treatment? _____
_____

Please initial each paragraph after reading.

_____ I acknowledge that this is an elective procedure at my request.
_____ I certify that I have listed all medications/medical procedures/ medical disorders.
_____ Fibroblasting with Plasma Pen cannot guarantee the exact outcome of this procedure and results may vary from client to client.
_____ I grant consent to photographs being taken BEFORE, DURING and AFTER my Plasma Pen procedure.
_____ I certify I have received written post treatment instructions
_____ I agree to follow all aftercare instructions to reduce the risk of post-procedural infection, hyperpigmentation and potential scarring.
_____ I agree to contact the service provider with questions or concerns pre or post treatment.
_____ I confirm I have fully read, understood and completed this Medical Conditions and Informed Consent Form and that the procedure known as Plasma Pen has been fully explained to me. I have had the opportunity to ask questions about the treatment and that my questions have been answered. I understand the importance of fully revealing my accurate and complete medical history. I understand that withholding any medical information may be detrimental to my health and safety both during and after my procedure and I confirm that I have not withheld any medical information. I understand that if there is any change in my medical history it is my responsibility to inform my technician. I understand that for the desired outcome several treatments may be required and this has been explained to me. I also understand no guarantee has been given as to what the outcome of treatment may or may not be. By my signature I affirm that I am at least 18 years old and freely give my informed consent to receiving treatment.

CLIENT NAME: _____SIGNATURE: _____DATE: _____
TECHNICIAN NAME:_____ SIGNATURE: _____DATE:_____