Neroli
Institute

☐ 6051 Arlington Blvd, Suite B,
Falls Church, VA 22044
703.241.2173

☐ 1880 Howard Ave, Suite 203
Vienna, VA 22182
703-356-6143

HEALTH HISTORY INFORMATION

IPL AND LASER HAIR REMOVAL

NAME **Today's Date:**

LAST: **FIRST:** **M.I:**

HOME ADDRESS:

DATEOF BIRTH: **AGE:** **Sex:** **Female** ☐ **Male** ☐

HOME PHONE: **CELL PHONE:**

EMAIL:

I consent to this email address to be added to the Med Spa and will be used to send email and newsletter, where I will get information on specials and promotions. Yes ☐ **No** ☐

LEAVE MESSAGES AT: Home ☐ **Cell** ☐ **Email** ☐

OCCUPATION:

PRIMARY CARE PHYSICIAN|PHONE NUMBER:
IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? [name and phone]

UNLESS OTHERWISE INDICATED, WE HAVEPERMISSION TOCOMMUNICATE CHANGES IN YOUR HEALTH STATUS, INCLUDING SURGERY, TO OTHER PHYSICIANS PARTICIPATINGIN YOURCARE.
Yes, May Notify ☐ **No, Please Do Not Notify** ☐

DOYOU HAVE ANY MAJORMEDICAL PROBLEMS, SERIOUS ILLNESS? Yes ☐ **No** ☐
IF SO, PLEASE LIST:

PLEASE LIST ALL PRIOR SURGICAL PROCEDURES ANDDATESPERFORMED:

PLEASE LIST ALL INJECTABLE PROCEDURES {Botox, Jevederm, Restylane, Collagen, etc.} AND DATES PERFORMED.

MEDICAL HISTORY

DO YOU HAVE APACEMAKER OR DEFIBRILLATOR?..... ☐

DO YOU SUFFER FROM "PHOTOSENSITIVITY" {EXTREME SENSITIVITY TOSUNLIGHT} ..... ☐

DO YOU HAVE A HISTORY OF EASY/EXCESSIVE HYPERPIGMENTATION?..... ☐

DO YOU FORM KELOID SCARS?..... ☐

DO YOU HAVE ANY METAL IMPLANTS?..... ☐

DO YOU WEAR CONTACT LENSESES?..... ☐

HAVE YOU TAKEN ACCUTANE, RETIN A, OR RENOVA IN THE PAST 12MONTHS?..... ☐

ARE YOU CURRENTLY TAKINGCOUMADIN [Warfarin]OR OTHER BLOOD THINNERS?..... ☐

DO YOU REQUIRE ANTIBIOTICS BEFORE PROCEDURES SUCH AS DENTAL CLEANINGS?..... ☐

DO YOU SMOKE? Yes ☐ No ☐ IF YES, HOW MANY PACKSPER DAY?

DO YOU DRINK ALCOHOL? Yes ☐ No ☐ IF YES, QUANTITY PER WEEK?

HAVE YOU EVER HAD AN ADVERSE REACTIONTO LASER OR COSMETIC TREATMENTS?
Yes ☐ No ☐ IF SO, PLEASE LIST:

ARE YOU ALLERGIC TO ANY MEDICATIONS?..... ☐
IF SO, PLEASE LIST:

DO YOU HAVE ANY OTHER ALLERGIES?..... ☐
IF SO, PLEASE LIST:

DO YOU TAKE ANY OF THE FOLLOWING **[Please check]:**

- ☐ **all that apply and/or list additional medications**
- ☐ **ANTI-COAGULANTS**
- ☐ **ANTI-DEPRESSANTS**
- ☐ **APPETITE DEPRESSANTS**
- ☐ **ASPIRIN OR IBUPROFEN**
- ☐ **BLOOD PRESSURE MEDICATION**
- ☐ **CORTISONE OR STEROIDS**
- ☐ **ANTIBIOTICS**
- ☐ **HORMONES/CONTRACEPTIVES**
- ☐ **NSULIN**
- ☐ **NSAIDS**
- ☐ **SEDATIVES**
- ☐ **THYROID MEDICATION**
- ☐ **OTHER**

ARE YOU TAKING HERBAL PREPARATIONS OR VITAMINS [St. JohnsWort, Vitamin E, etc.]? **Yes** ☐ **No** ☐
ARE YOU OR MIGHT YOU BE PREGNANT?..... **Yes** ☐ **No** ☐
ARE YOU TRYING TO BECOME PREGNANT?..... **Yes** ☐ **No** ☐
ARE YOU NURSING?..... **Yes** ☐ **No** ☐

HAVE YOU EVER HAD ANY PROBLEMS WITH ANY OF THE FOLLOWING ANESTHETICS? IF SO, PLEASE SPECIFY:

- ☐ **BLOCK [e.g., dental]: Ineffective |Heart palpitations |Systemic reaction| Other:**
- ☐ **LOCAL: Ineffective |Heart palpitations |Systemic reaction| Other:**
- ☐ **TOPICAL: Ineffective |Heart palpitations |Systemic reaction| Other:**

HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING [Please check all that apply]:

- ☐ **Active Infection**
- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Bleeding Disorders**
- ☐ **Blistering Sunburns**
- ☐ **Circulation Problems/Blood Clots**
- ☐ **Cold Sores/Shingles**
- ☐ **Collagen Disorders**
- ☐ **Diabetes (Type__)**
- ☐ **Easy Bruising**
- ☐ **Endocrine/Hormonal Issues**
- ☐ **Eye Problems**
- ☐ **Fatigue**
- ☐ **Fibromyalgia**
- ☐ **Headaches/Migraines**
- ☐ **Heart Condition**
- ☐ **Hepatitis**
- ☐ **High/Low Blood Pressure**
- ☐ **Other**
- ☐ **Hormonal Imbalance**
- ☐ **Insomnia/Sleeping Problems**
- ☐ **Joint Injury**
- ☐ **Multiple Sclerosis**
- ☐ **Muscle Pain/Spasms**
- ☐ **Neurological Disorders**
- ☐ **Permanent Makeup/Tattoo**
- ☐ **Pigmentation Disorders**
- ☐ **Psoriasis**
- ☐ **Melanoma**
- ☐ **Scleroderma**
- ☐ **Skin Cancer**
- ☐ **Skin Injury**
- ☐ **Stroke**
- ☐ **Unusual Moles**
- ☐ **Varicose Veins**
- ☐ **Vision Deficits**
- ☐ **HIV/AIDS**

SKIN CARE HISTORY AND CONCERNS

PLEASE LIST ANY PRODUCTSTHATIRRITATEYOUR SKIN:

HAVE YOU HAD UNPROTECTED SUN EXPOSURE OR BEEN IN A TANNINGBOOTH IN THE LAST 2 WEEKS? Yes ☐ No ☐

DOYOU USE SELF TANNERS? Yes ☐ No ☐ IF YES, WHEN WAS THE LAST APPLICATION?
ARE YOU PLANNING A VACATIONIN THE SUN IN THE NEXT 3-6MONTHS? Yes ☐ No ☐

HAVE YOU USED ANY OF THE FOLLOWING HAIR REMOVAL METHODS IN THE PAST6WEEKS?
SHAVING ☐ WAXING ☐ ELECTROLYSIS ☐ PLUCKING/TWEEZING ☐ STRINGING ☐
EPILATORIES ☐
PLEASE INDICATEYOUR CURRENT SKIN CARE PRODUCTS/REGIMEN:

THERAPIST/PROVIDERREVIEWED: SIGNATURE _____ DATE_____
THERAPIST PRINTED NAME:

EXCLUSIONARY CRITERIA FORM

Yes ☐ No ☐	**I have had unprotected sun exposure, used a tanning Bedor applied a tanning cream inthe area(s) to be treated within the six weeks prior to my first treatment on a regular basis (tanned skin will not be treated with laser). Protected sun exposure means wearingprotective clothing or the daily use of an SPF-30 or greater sunscreen.**
Yes ☐ No ☐	**I have used a mechanical form of epilation with the six weeks prior to my first treatment (this applies to laser hair removal treatments only.) Mechanical epilation includes Plucking, waxing, tweezing, electrolysis, threading, or sugaring.**
Yes ☐ No ☐	**I have a history of seizures. Flashing lights may trigger a seizure.**
Yes ☐ No ☐	**Medications I am taking Accutane, anticoagulants or St.John's Wort. I am taking a medication or herbal remedy that may make my skin sensitive to light (photosensitizing).**
Yes ☐ No ☐	**I have a history of keloid and hypertrophic scar formation. Although scarring is rare, picking or pulling off scabs or crusting can result in scarring. For this reason, it is recommended to exclude from treatment clients with known tendency to form keloid or hypertrophic scars. Clients with this history are evaluated on a case-by-case basis to determine if treatment can be performed.**
Yes ☐ No ☐	**I have an active infection or am immune suppressed. (Active infections and immuno- suppression compromise the healing ability of the body).**
Yes ☐ No ☐	**I have an open lesion in the area to be treated.**
Yes ☐ No ☐	**I have a history of Herpes I or II within the area to be treated.**
Yes ☐ No ☐	**I am using or have used within the two weeks prior to treatment Tretinoin (Retin-A, Renova) or a retinol product in the area to be treated.**

PLEASENOTE A “YES” TO ANY OF THE ABOVE MAYEXCLUDE CLIENT FROMTHE LIGHT THERAPY (LASER/IPL) TREATMENTS.

PRINT CLIENT NAME:

SIGNATURE: DATE:

WITNESS: DATE:

MY SPECIFICCONCERNS AND INTERESTS

Please check all that apply and indicate any prior treatments in space provided)

CONCERNS	LIST ANY PRIOR TREATMENT AND APPROXIMATE DATE(S): [Accutane/Botox/Peels/IPL/Lasers/Surgery/etc.]
◯ Skin discoloration	
◯ Brown Spots	
◯ Acne	I have used Accutane: Yes ◯ No ◯ Last Dose:
◯ Rosacea	
◯ Fine Wrinkles	
◯ Lip Lines	
◯ Thin Lips	
◯ Nasolabial Creases	
◯ Marionette Lines	
◯ Loose Skin	
◯ Aging Hands	
◯ Excessive Sweating	
◯ Facial/Body Hair	
◯ Scars	
◯ Facial Veins	
◯ Leg Veins	
◯ Not Certain	
◯ Toenail Fungus	
◯ CoolSculpting Body Contouring	
◯ Other	

CLIENT SIGNATURE: **DATE:**

PRINTEDNAME:

PROVIDER NAME ANDSIGNATURE: **DATE:**

PROVIDER NAME AND SIGNATURE: DATE:

THE FITZPATRICK SKIN-TYPE CHART

You can use this skin-type chart for self-assessment, by adding up the score for each of the questions you've answered. At the end there is a scale providing a range for each of the six skin-type categories. Following the scale is an explanation of each of the skin types. You can quickly and easily determine which skin type you are.

GENETIC DISPOSITION

Score	0	1	2	3	4
What is the color of your eyes?	Light blue, Grey, Green ☐	Blue, Grey, Green ☐	Blue ☐	Dark Brown ☐	Brownish Black ☐
What is the natural color of your hair?	Sandy Red ☐	Blond ☐	Chestnut/ Dark Brow ☐	Dark Brown ☐	Black ☐
What is the color of your skin (non-exposed areas?)	Reddish ☐	Very Pale ☐	Pale with Beige tint ☐	Light Brown ☐	Dark Brown ☐
Do you have freckles on unexposed areas?	Many ☐	Several ☐	Few ☐	Incidental ☐	None ☐

TOTAL SCORE FOR GENETIC DISPOSITION: _____

REACTION TO EXPOSURE

Score	0	1	2	3	4
What happens when you stay in the sun too long?	Painful redness, blistering, pooling ☐	Blistering followed by peeling ☐	Burns sometimes followed by peeling ☐	Rare Burns ☐	Never had Burns ☐
To what degree do you turn brown?	Hardly or not at all ☐	Light color tan ☐	Reasonable tan ☐	Tan very easy ☐	Turn dark brown quickly ☐
Do you turn brown within several hours after sun exposure?	Never ☐	Seldom ☐	Sometimes ☐	Often ☐	Always ☐
Do you have freckles on unexposed areas?	Very Sensitive ☐	Sensitive ☐	Normal ☐	Very resist ance ☐	Never had a proble m ☐

TOTAL SCORE FOR REACTION TO SUN EXPOSURE: _____

TANNING HABITS

Score	0	1	2	3	4
When did you last expose your body to sun [or artificial sun lamp/tanning cream?	More than 3 months ago ☐	2-3 months a go ☐	1-2 months a go ☐	Less than a month ☐	Less than 2 weeks ☐
Did you expose the area to be treated to the sun?	Never ☐	Hardly ever ☐	Sometimes ☐	Often ☐	21 ☐

TOTAL SCORE FOR TANNING HABITS: _____

Add up the total scores for each of the three sections for your* Skin Type Score. *

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SKING TYPE SCORE – FITZPATRIK SKING TYPE

0-7	**I**
8-16	**II**
17-25	**III**
25-30	**IV**
Over 30	**V-VI**

TYPE 1: Highly sensitive, always burns, never tans.
Example: Red hair with freckles.

TYPE 2: Very sun sensitive, burns easily, tans minimally.
Example: Fair skinned, fair haired Caucasians.

TYPE 3: Sun sensitive skin, sometimes burns, slowly tans to light brown.
Example: Darker Caucasians.

TYPE 4: Minimally sun sensitive, burns minimally, always tans to moderate brown.
Example: Mediterranean type Caucasians, some Hispanics.

TYPE 5: Sun insensitive skin, rarely burns, tans well.
Example: Some Hispanics, some Blacks.

TYPE 6: Sun insensitive, never burns, deeply pigmented.
Example: Darker Blacks.

INFORMED CONSENT FORM IPL and LASER HAIR REMOVAL

CLIENT NAME: **DATE:**

TREATMENT SITES:

I DULY AUTHORIZE NEROLI MED SPA'S TECHNICIANS TO PERFORM _____ _____TREATMENT.

I UNDERSTAND THAT CLINICAL RESULTS MAY VARY DEPENDING IN INDIVIDUAL FACTORS, INCLUDING BUT NOT LIMITED TO MEDICAL HISTORY, SKIN TYPE, PATIENT COMPLIANCE WITH PRE AND POST TREATMENT INSTRUCTIONS, AND INDIVIDUAL RESPONSE TO TREATMENT.
INITIALS _____

I UNDERSTAND THAT THERE IS A POSSIBILITY OF SHORT-TERM EFFECTS SUCH AS REDDENING, MILD BURNING, TEMPORARY BRUISING AND TEMPORARY DISCOLORATION OF THE SKIN, AS WELL AS THE POSSIBILITY OF RARE SIDE EFFECTS SUCH AS SCARRING AND PERMANENT DISCOLORATION. THESE EFFECTS HAVE BEEN FULLY EXPLAINED TO ME.
INITIALS _____

I UNDERSTAND THAT TREATMENT WITH THE _____ INVOLVES A SERIESOF TREATMENTS AND THE FEE STRUCTURE HAS BEEN FULLY EXPLAINED TO ME.
INITIALS _____

I CERTIFY THAT I HAVE BEEN FULLY INFORMED OF THE NATURE AND PURPOSE OF THE PROCEDURE, EXPECTED OUTCOMES AND POSSIBLE COMPLICATIONS, AND I UNDERSTAND THAT NO GUARANTEE CAN BE GIVEN AS TO THE FINAL RESULT OBTAINED. I AM FULLY AWARE THAT MY CONDITION IS OF COSMETIC CONCERN AND THAT THE DECISION TO PROCEED IS BASED SOLELY ON MY EXPRESSED DESIRE TO DO SO.
INITIALS _____

I CONFIRM THAT I HAVE INFORMED THE STAFF REGARDING ANY CURRENT OR PAST MEDICAL CONDITION, DISEASE OR MEDICATION TAKEN.
INITIALS _____

I CONSENT TO THE TAKING OF PHOTOGRAPHS AND AUTHORIZE THEIR ANONYMOUS USE FRE THE PURPOSE OF MEDICAL AUDIT, EDUCATION AND PROMOTION.
INITIALS _____

I CERTIFY THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS AND THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS CONSENT FORM.
INITIAL _____

CLIENT SIGNATURE: **DATE:**

Laser Hair Removal Informed Consent Form

1. Informed Consent

The purpose of this Informed Consent is to help you decide whether a laser hair removal ("LHR “) cosmetic procedure is right for you and to help you make an informed decision to undergo this procedure. This informed Consent gives you general information about LHR cosmetic procedures, explains other treatment options, and identifies the benefits, risks, side effects and possible complications associated with LHR procedure

2. Laser Hair Removal Procedure

LHR is a non-invasive laser treatment designed to remove unwanted hair from all parts of the body. The laser device
works by emitting pulses of light energy that penetrate the skin and destroy hair follicles while the device’s hand.
piece cools the surrounding skin. Because the laser needs to fill the hair follicle to work effect lively, it is important not to wax, tweeze, have electrolysis procedures, or pluck hair for 2-4 weeks prior to the procedure.

You will be required to wear protective eyeglasses during the procedure to protect your eyes from the laser light. You may feel a slight burning, stinging or pinching sensation during the procedure. It generally takes IO to H days after the procedure for the treated hair to fall out. Treatment of dark course hair generally achieves the best result while removal of light fine hair generally requires additional treatments which may or may not be successful. Clinical results of LHR may also vary depending on individual skin type. hormonal level s and hereditary influences. Therefore, some patients may experience partial results, and some may notice no improvement at all. Future hormonal changes may cause additional hair growth. LHR procedure generally involves a series of treatments. Ideal (light skin dark hair) candidates can usually achieve 65%-90% reduction with a series of 6 treatments. Thicker skinned areas such as men 's backs, faces or neck usually require more than 6 session s and usually achieve only partial reduction or hair thinning.

3. Alternative Procedures

LHR is a voluntary cosmetic procedure which is not necessary or required. Not doing the procedure is an option.

4. Not Good/No Candidates

Generally, you are not a good candidate for LHR procedure if you are pregnant, nursing or plan to become pregnant while undergoing LHR treatments. Individuals who have used Accutane within the past so: months or who used any medications requiring limited exposure to sunlight are not good candidates for LHR procedure. individuals with recently tanned skin are advised to

delay undergoing the LHR procedure. The laser may not be effective on blond or gray hair.

Sun exposure 2-4 weeks prior to treatment may reduce effectiveness of the laser. It is important to shave the area prior to treatment session. (We do not provide shaving services as you must do this yourself prior to the treatment). Please inform us if you have an allergy to Aloe.

5. Risks and Complications

All medical and cosmetic procedures are associated with certain risks and may result in complications. Some but not all the possible risks and complications associated with LHR procedure include:

- Temporary reddening, burning, swelling, bruising or discoloration of the skin over the treated area.

- Blistering, scarring, activation of cold sores, infection, or permanent discoloration, which may occur in rare cases. Please inform us if you have ever had a problem with cold sores.
- Folliculitis, which is an infection of the hair follicle, which may take several days to, resolve.

- Hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the s: in), which rare may take several months to fully resolve

- Crusting or blistering of the area exposed to laser. which is rare and which may take several) days to heal.

- As with all LHR procedures, some re-growth of hair may occur after treatment sessions are completed.

6. Post Procedure Instructions

It is important that you comply with all post procedure instructions. In addition, it is important that you limit sun exposure after the LHR procedure and use protective sunscreen lotion. Please call our- doc tor promptly if complications develop after the procedure. Laser-treated areas should not be exposed to, sun or tanning beds not adhering to the post treatment skin care instructions may increase the risk of complications.

___The information contained in this Informed Consent was explained to me using terms I could understand, and all my questions and concerns have been answered. After reviewing all the information provided to me about cosmetic procedures and reviewing my health, status, I believe I am a good candidate for LHR procedure.

___ I understand that LHR is an elective procedure and hereby freely accept all possible risks, complications and side effects that may result from this procedure.

___This consent form is valid for all future laser hair removal treatments performed, and if I will alert the staff if there are any future changes to my medical history, or if I become pregnant

___ I am not pregnant, nursing, or trying to become pregnant.

___ I have stopped use and been off all antibiotics, or any other dmg that may cause photosensitivity, for at least 7 days.

___I have not used Accutane or any other isotretinoin medication in the past 6 months.

___I have not used self-tanner in the area to be treated in the past 7 days

___I have not received electrolysis, tweezed, waxed, threaded, or removed hair from the follicle any method other than shaving in the past 3-4 week.

___I am aware if I have herpes simplex virus I or 2, I need to be on an oral antiviral medication at least 2-3 days prior to laser treatment.

___Laser hair removal produces an intense burst of light and light energy to selectively heat. remove, and/or reduce hair.

_____ For best results, I have been informed multiple treatments will be necessary.
For best results, I understand laser hair removal treatments need to be scheduled consecutively and it is recommended they are scheduled 4-6 weeks apart depending on the area being treated.

___I understand laser hair removal is based on the principles of selective photosensitivity, and it is a combination of the appropriate laser wavelength, pulse duration, and fluence. Not all laser hair removal devices are not the same wavelengths, pulses, and/or fluence.

___I understand that all lasers and/or laser hair removal devices are not the same and, if I have had laser hair removal treatments somewhere else or do so in the future, the laser treatment I received may not be the same as the laser treatment I will receive at Optima derma.

___I understand complete removal and/or clearing of my hair may not be possible.

___I understand maintenance may be needed after my initial series of treatments; and new hair growth may occur in the treated area. This new hair growth may be caused by various factors including age, hormones, and/or new medications.

___I understand the risks and complications that may be associated with this procedure. I have been informed about the risks and complications may include, but are not limited to:

- Bruising arid purpura (red--purple discoloration)

- Bleeding
- Infection
- Hyperpigmentation (darkening of the skin) and may be permanent
- Hypopigmentation (lightening of the skin) and may be permanent
- Itching or a hive-like response
- Bums, blisters, textural changing or scarring
- Swelling, redness and/or discomfort

___I am aware this procedure may activate individual sensitivities. These sensitivities may include, but are not limited to:
Herpes simplex virus, which can cause cold sores and fever blisters, hirsutism (increased hair growth), an/or Lymphadenopathy (enlarged lymph nodes).
___After laser treatment, redness, swelling, welting, itching, dry skin and/or discomfort may occur. 1 understand 1ile se complications typically resolve within a few hours, days, weeks, or months; however, some complications such as scarring, hyperpigmentation, and/or hypopigmentation may be permanent.
___I understand any redness, swelling, and/or discomfort usually resolves within several hour but may last for 2- 3 days. The treated area may feel like a sunburn or windburn (minor discomfort) for a few hours after treatment. Discomfort may be treated with the application of cool compresses, antibiotic ointment, Aqm1phor, and/or topical soothing agents.
___I am aware I will be given aftercare instructions regarding care of the treated areas. I understand it is important to follow all aftercare instructions carefully to minimize the risks of incomplete healing, scarring. and/or skin textural changes.
___I am aware that there are other methods of treatment available for hair removal and have assessed the risks and benefits of laser hair removal and these alternative methods.
Anesthesia is usually not necessary for this procedure. My provider and I may elect to use a form of anesthesia a lo reduce my discomfort during the procedure. A cryogen spray skin cooling device may be used during the procedure to decrease discomfort, md protect the skin.
___I understand I need to avoid direct sunlight, because sun sensitivity of the treated are.1 may remain for several weeks after a laser treatment.
___I understand I need to protect my skin from the sun, and I need to use a broad spectrum UVNUVB protective sunscreen to reduce the risk of damage to the skin. I understand I must wear a broad-spectrum U\VUVB protective sunscreen during instances where I am exposed to sunlight. These instances include, but are not limited to:

- **sitting in the car**
- **walking to the mailbox**
- **sitting next to a window to reduce the risk of damage to the skin.**

___ I understand my skin may be sensitive for a week or more after laser treatment and I: should avoid using extremely hot water and skin care products that may cause irritation. These skin care products may include, but are not limited to scrubs, toners, retinoids, glycolic acids, anti-aging ingredients, and/or acne products.

___I understand hair growth occurs in three different cycles which are explained to me clearly and the hair must be in the Anagen phase of growth in order for laser hair removal to work. The duration of hair cycle and percentage of hair in the Anagen (growth) phase is different for all areas of the body. I also understand the depth of the hair follicle varies throughout the body. Age, ethnicity, metabolism, medications, and changes in hormones affect the location, resilience, and thickness of hair. I understand these factors influence the success of laser treatments, why multiple treatments are needed and, why we are unable to predict the number of treatments each individual will need to be satisfied with the results.

___I understand laser hair removal is a cosmetic procedure that is elective and is not covered by insurance.

___I understand, recognize, and acknowledge the physicians, practitioners, delegated stalli1MG, assistants, and specific technicians and the facility, its affiliates, officers, directors and/or representatives have made no guarantees to me concerning the results of my laser treatments.

___I have provided my past and current medical history and medications.
Contraindication s of this procedure has been discussed in detail with me.

___I have read and understand all information presented to me concerning this procedure before signing this consent form.

___Questions I have about the risks, benefits, and results pertaining to this procedure have been answered and discussed to my satisfaction.

___I hereby commit myself not to leave any comments or information in any social media or elsewhere, or communicate, with any entity, any such comments or information that may damage the reputation of NEROLI in any fom1 or extent whatsoever, and will only share any such comments and feedback with NEROLI.

___I understand that my commitments, consent and other contents stated in the present

document shall survive after the completion of the services or even I elect to stop receiving the services at any stage thereof.

l hereby release the physicians, practitioners, delegated staff/IMG, assistants, and specific technicians and the facility, *its* affiliates, officers, directors and/or representatives from all liability, covenants, obligation s, claims and sum of money arising out of or in association and connection with my procedure(s) treatment(s), together with any rights and causes of actions that I may have had against the physicians, practitioners, delegated staff/I MG, assistants and specific technicians and the facility, its affiliates, officers, directors and/or representatives. This release shall be
binding upon my heirs, executors, administrators, and assigns, who jointly and severally with myself waive and defenses to the strict enforcement of the provisions of this release and consent. I certify that I am a competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns. I hereby give my consent lo this procedure and have been asked to sign this form after my discussion and consultation with.

Refund , Return and Cancellation Policy

As a courtesy to other Spa guests and our therapists, please give at least a 48-hour notice of cancellation to avoid a $25 charge or as a penalty one of your sessions taken away. A credit-card number , advanced payment, or gift-certification number may be required at the time of booking. For spa packages and two or more guests coming together we require a 48 - hour cancellation notice. Groups and bridal parties will require a 50% deposit at the time of booking. A refund is not available after you have used a portion of the services you booked.After one session the fee for package of two is non-refundable.Please ask new update of our staff about our refund and return and cancellation policy.Educational programs After two sessions the fee for programs is non-refundable.We do not provide refunds for cancelled or missed appointments.

CLIENT SIGNATURE: **DATE:**

NEROLI MED SPA

LASER HAIR REMOVAL PATIENT CONSENT FORM

I, the client, (patient's name)_____certify that I have read and understood the content of this informed consent form, and gave **ACCURATE** information as to my health condition and sun exposure (A – J) to **AVOID COMPLICATIONS SUCH AS BURNS.**

TREATMENT AREA TODAY (___/___/ 20_____): _____

 CIRCLE **YES "Y"** or **NO "N"** FOR ***BEST RESULTS***: 

A. Within the past 4-6 weeks, were you exposed to the **SUN**, like on the beach, pool, walking outside for long periods, outside sports, vacation… **YES** **NO**

B. Within the past 4-6 weeks, were you exposed to **TANNING BOOTHS?** **YES** **NO**

C. Have you used any **SELF-TANNERS** in the past 4 weeks? **YES** **NO**

D. Have you taken **Accutane** (Isotretinoin) within the past year? **YES** **NO**

E. Are you using any creams that contain: **RETIN-A OR RETINOL** on the treatment area? (Generally used on the face) **YES** **NO**

F. Are you currently taking PHOTOSENSITIZING **medication or supplements?** **YES** **NO**

G. Are you **PREGNANT**, suspect you may be pregnant, or nursing? **YES** **NO**

H. Is there a presence or history of active **cold sores or herpes simplex virus?** **YES** **NO**

I. Have you had **SKIN CANCER**? **YES** **NO**

J. Have you **BLEACHED, WAXED, TWEEZED** treatment are within last 4-6 weeks? **YES** **NO**

K. Have you had any **PREVIOUS HAIR REMOVAL** procedures on requested treatment area? **YES** **NO**

I UNDERSTAND that my signature certifies that I have read and understood that if I did not tell the truth or am not sure about any of the following above, laser can result in **BURNING, SCARRING, BRUSING, SCABBING, BLISTERING and/or DISCOLORATION and IRRITATION.**

Patient Signature:_____Date:_____/_____/_____

(NEROLI MED SPA COPY ON FILE)

Consent For Laser Hair Removal

I_____(patient's name), authorize the technicians at Neroli Med Spa to perform Laser Hair Reduction treatment(s) on me. There are several
alternatives to laser hair removal including but not limited to electrolysis, shaving, waxing andplucking or no treatment at all.

I understand that serious complications are rare but possible. Common side effects include temporary redness, swelling and mild "sunburn" like effects that may last a few hours to 3-4 days or longer on the treated area. Other potential risks include itching, pain, bruising, burns,infection, scabbing, blistering, hypopigmentation, hyperpigmentation, scarring, and failure to achieve the desired result(s). **Initial**____

I understand that a single procedure will most likely fail to completely remove all my unwantedhair on the treated area. Multiple treatments are required. Individual response will vary according to skin types, hair color, degree of tanning, follow up care, and the body area being treated.

I understand that treatment can be painful, but this is typically managed without any pain reliefmedication. Discomfort generated by that laser pulse is most commonly described as a rubber band snapping against the skin. Topical anesthetics are available to decrease any perceived discomfort. Color changes, such as hyperpigmentation (brown/red discoloration) or hypopigmentation (skin lightening), may occur in the treated skin. This may take several months to resolve, if at all. Unprotected sun exposure in the weeks following treatments is contraindicated as it may cause or worsen this condition. Blistering of the skin may occur.
Scarring happens but is uncommon.

Lasers can cause eye injury and protective eyewear must be worn during treatment. I understand that sun or tanning lamp exposure and not adhering to the post-care instructions provided to me may increase my chances of complications. I understand that norefunds will be given for treatments or for treatments paid in advance. I have read, been explained and understand as well as given the post-treatment instructions.

Initial ____

_____/_____/_____

Patient Signature Date