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

Intense Pulsed Light (IPL)

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 in the 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 wearing protective 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:**

Chemical Peel Consent & Treatment Instructions

INSTRUCTIONS

This is an informed consent document prepared to assist your Physician, Registered Nurse, and/or certified Aesthetician in informing you about skin peel and skin treatment procedures, their risks, and alternative treatments. Please read this information carefully and completely.

DISCLAIMER

Informed-consent documents are used to communicate information about the proposed surgical treatment of a disease or condition along with disclosure of risks and alternative forms of treatment(s). The informed-consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed-consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your Physician, Registered Nurse, and/or certified Aesthetician may provide you with additional or different information which is based on all the facts in your particular case and the state of medical knowledge. Informed-consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

- Use of Accutane in the last 6 month
- Active Herpes simplex (cold sores)
- Facial warts
- If you are pregnant, think you might be pregnant, or are trying to become pregnant
- If you have a history of herpes simplex
- Prior bad reaction or allergies
- Recent tanning
- Sunburn
- Recent significant sun exposure or laser within the last 2 weeks
- Surgery or surgery within the last month to the area to be peeled
- Allergies to salicylic acids
- Blood vessel disease
- Diabetes
- Inflammation, irritation or infection of the skin
- Influenza
- Varicella (chicken pox)
- Kidney or liver disease

Chemical Peel Consent & Treatment Instructions

What To Do Before Your Peel

1. Do not apply Retin-A, Renova, Tazorac, and/or Differin 2 weeks prior to and 2 weeks after your treatment, to the treatment area, or as instructed by your Physician, Registered Nurse, or certified Aesthetician.

2. Do not sun tan or use a tanning bed 2–4 weeks prior to and 2–4 weeks after your treatment.
3. Stop any type of depilatory treatments (waxing, depilatory creams) to the area of treatment 2 weeks prior to and 2 weeks after your peel.
4. Stop electrolysis, and any type of laser treatments (laser hair removal, IPL) to the area of treatment, 2-4 weeks before and 2-4 weeks after your peel or as instructed by your Physician, Registered Nurse or certified Aesthetician.

Chemical Peels Post Treatment Care

1. When cleansing, do not scrub. Use a gentle cleanser as directed by your Physician, Registered Nurse, or certified Aesthetician at ----------
2. With any peel, your skin may start to peel 1–3 days after the peel and continue to peel for 2–5 more days; however, it is also possible that your skin may not peel at all.
3. Do not peel, pick, or scratch the treated area, as this may result in scarring.
4. Apply Polysporin, Bacitracin, or Vaseline to dry, flaky areas, or as directed by your Physician, Registered Nurse, or certified Aesthetician.
5. Do not have any other facial treatments for at least 2 weeks after your peel or until the skin is smooth and back to normal.
6. If given a cortisone cream by your Physician, Registered Nurse, or certified Aesthetician, please apply it 1–3 times per day to red, irritated areas or as directed. Follow any additional instructions given to you by your provider.
7. Always wear your sunscreen; apply a sunscreen with SPF 30 every morning.

   After Peel: Patients may have tightness and smoothness immediately post-peel. Peeling usually begins 1–2 days after the peel and can extend up to 7 days. Transient hyperpigmentation and superficial crusting are possible in areas of inflamed acne. Skin Type III may experience darkening after the peel due to increased shedding of the outer layers. Minor side effects may include, but are not limited to, superficial crusting, edema, temporary bruising of the lower eyelid areas, hypopigmentation, temporary dryness, and hyperpigmentation, all of which typically resolve quickly.

The Physician, Registered Nurse, or certified Aesthetician at **NEROLI** explained to me the process of peeling the skin by various acids, which are called chemical peels. I understand that side effects may include, but are not limited to, increased color, decreased color, infection, pain, bleeding, swelling, scarring, or damage to nearby structures, nerves, drug reactions, or unforeseen complications.

------I have received an instruction sheet on how to care for my skin prior to and following this procedure and agree to abide by it. I understand that proper sun protection, including but not limited to the faithful use of broad-spectrum UVA–UVB sunblock with SPF 30, is vital to proper aftercare and to reducing the risks of undesired side effects.

------I understand that there is a possibility that this procedure will fail, be unsuccessful, need to be repeated, or may require additional treatment for complications.

------I understand my responsibility for properly fulfilling the appropriate aftercare instructions as explained by the Physician, Registered Nurse, or certified Aesthetician, and hereby release and hold harmless my Physician, Registered Nurse, and/or certified Aesthetician and their suppliers from any consequences resulting from my failure to properly fulfill such aftercare instructions.

------I further understand that this is a superficial type of peel that normally creates, at most, only mild redness with occasional areas of flaking or peeling skin. Depending on my skin, this may last 2–7 days.

------I am aware that on rare occasions this peel can penetrate deeper in certain areas, causing a crusted scab to form. I understand that if this area is not treated appropriately it could become infected and possibly lead to the formation of a scar. It is my responsibility to contact my provider if any crusted areas form or if my skin does not look and feel completely normal within one week after my peel. I acknowledge this and desire that this product be applied to my skin.

------I am undergoing this peel in an effort to improve my skin texture and color. I understand I may achieve some improvement in my fine wrinkles as well, but no guarantee has been made regarding my level of improvement. The Physician, Registered Nurse, or certified Aesthetician at NEROLI has explained to me that I may need several of these peels to achieve optimal results.

------I understand and am willing to comply with all pre- and post-care instructions. This procedure has been explained to me, and my questions regarding the treatment, alternatives, complications, and risks have been answered. I have been asked whether I have any further questions, and I do not. I understand the procedure, accept the risks, and request that this procedure be performed on me by a Physician, Registered Nurse, or certified Aesthetician at NEROLI. The information given to me is completely clear, and I understand all risks and complications. My questions have been fully answered, and I have read and understand this document. I hereby give my unrestricted informed consent for the procedure.

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

------ I understand that my commitments, consent, and other contents stated in this document shall survive after the completion of services or even if I elect to stop receiving services at any stage.

Refund, Return, and Cancellation Policy

As a courtesy to other Spa guests and our therapists, please provide at least a 48-hour notice of cancellation to avoid a $25 charge or, as a penalty, one of your sessions being taken away.

A credit-card number, advanced payment, or gift-certificate number may be required at the time of booking.

For spa packages and for 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 a package of two is non-refundable. Please ask our staff for any updated information regarding our refund, return, and cancellation policy.

Educational programs: After two sessions, the fee for the program is non-refundable.

We do not provide refunds for cancelled or missed appointments.

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.

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Intense Pulsed Light (IPL) Consent Form

The Intense Pulsed Light (IPL) device used for the treatment of benign pigmented and vascular skin lesions and rejuvenation and acne. IPL treatments are a series of approximately 4 to 6 treatments performed at approximately 2 week intervals. Actual results vary from patient to patient. The IPL treatment is a cosmetic procedure and insurance is not accepted.

The procedure is contraindicated in the following situations: pregnancy, the use of medications that cause photosensitivity (sensitivity to sunlight/light), the use of anticoagulants (blood thinners), a history of bleeding disorders, sun exposure (tanning) 3weeks prior to treatment, or planned sun exposure within 1 week after any treatment. Diseases that increase sensitivity to sunlight/light(Lupus/SLE) or very dark skin types also should not undergo IPL treatments.

I understand that there are possible risks to these treatments, similar to any other medical procedure. These risks include rare side effects such as scarring and permanent skin discoloration as well as short- term effects such as redness, burning, bruising and temporary skin discoloration. These side effects have all been fully explained to me and I accept the risks of the IPL treatment series.

I understand that IPL treatments may affect hair growth. For this reason, we do not treat over men's bearded areas unless expressly discussed with the R.N.

To achieve optimal results from the IPL treatment series, we strongly encourage maintenance treatments. Usually this consists of 1 treatment every 2-4 weeks depending on skin conditions.

I consent to the taking of photographs during the course of my laser therapy for the purpose of monitoring the progress of treatment. These photographs will remain in the medical chart and will not be used for any other purposes.

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.

Patient Signature: _____ Date: _____

Patient Name: _____
(Please Print)

Witness: _____Date: _____

POLICIES

24 HOURS CANCELLATION POLICY

Confirmation of your appointments is a courtesy call not an obligation. It is the client's full responsibility to keep track of his/her scheduled appointments. If a client fails to notify of appointment cancellation at least 48 hours in advance, the no-show will be counted as used treatment of the client's package deal or a $40.00 fee must be paid to accommodate the licensed technician time. For any credit card payments, a 10% surcharge and merchant fee will be deducted in case of any refunds 14(fourteen) days after original transaction.

PACKAGE REFUND POLICY

By signing this No Refund policy, I am agreeing that any service(s), service package(s) , gift certificate(s), and/or retail product(s) purchased will not be refunded or issued a credit. refunded or issued a credit. I also understand that if I decide to cancel or postpone any service(s), service package(s),gift certificate(s), and/or retail product(s), I will forfeit all money paid, including any deposits and/or payments I have already paid.All package payments should be completed in full before no more than half of the services have been used.

Full Name:

Signature:

Date: ___/__/_____

For Official Use Only

Purchase package :

Number of package :

Expiration :

Officer Signature :

I agree with all terms and conditions