Personal History (please print clearly)

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

Date of Birth: _____ Age: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Best number to reach you (circle): Home Work Cell Email address: _____

Emergency Contact: _____ Contact Number: _____

How were you referred to us? _____

General History

Have you ever had laser treatments? Yes ___ No___ If so, for what and where? _____

Does your skin turn really red after a shower or a glass of wine? Yes ___ No___

Have you had any surgeries? Yes ___ No ___If so, for what? _____

Do you have any tattoos? No ____ Yes (where?)_____

Do you burn easily in the sun if you're not wearing sunscreen? Yes _____ No _____

What is your ethnicity/heritage? (please include percentages)

_____ Scandinavian
_____ Northern European (Light Caucasian)
_____ Dark Caucasian
_____ Mediterranean, Italian, Asian, or Hispanic
_____ Middle Eastern, Latin, Light African-American, Darker Hispanic, Indian, or Native American
_____ Dark African American

Are you concerned about any of the following? (Please check all that apply).

_____ Wrinkles or loose skin on face
_____ Hair in the wrong place
_____ Brown or red spots
_____ Acne on any part of my body
_____ Other: _____
_____ Dry, flaky skin or oily skin
_____ Red, blue, or purple spider veins on face, nose, or legs
_____ Unwanted tattoo(s)
_____ Scars

Medical History

Are you currently under the care of a physician or dermatologist? Yes _____No _____ If yes, for what:
_____

Do you have any of the following medical conditions? (Please circle all that apply).

Cancer Diabetes High blood pressure Herpes Arthritis Rosacea
Frequent cold sores HIV/AIDS Keloid scarring Skin disease/Skin lesions Seizure disorder
Hepatitis Hormone imbalance Thyroid imbalance PCOS Any active infections
Blood clotting abnormalities Erythema Abigne

Please list any other health problems or medical conditions you have, including internal metal devices, or pacemaker: _____

Have you ever had an allergic reaction to any of the following? *Please circle all that apply:*

Food Latex Aspirin Lidocaine Hydrocortisone Ice/Cold
Hydroquinone or skin bleaching agents Other: _____

What oral medications are you presently taking? Birth Control Hormones Other: _____

Are you on any mood altering or anti-depression medication? Yes ___ No ___ What: _____

Have you used Accutane? Yes ___ No ___ If yes, when did you last use it? _____

Do you regularly take baby aspirin, Coumadin, or other blood thinner? Yes ___No ___

What topical medications or creams are you currently using? Retin A or Other: _____

Do you take fish or flax oil supplements: Yes _____No_____ Ginkgo: Yes _____ No _____

What other dietary supplements do you take regularly? _____

Are you pregnant or trying to become? Yes ___No __Are you breast feeding? Yes ___ No ___

Are you using hormonal contraception? Yes ___No ___When is your next period? _____

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, staff, or nurse of my current medical or health conditions and to update this history. I understand there are no refunds offered on unwanted treatments, and no returns are given for treatments with unsatisfactory results. I agree that if I experience negative or unexpected side effects I will first to be seen by Smooth Skin Centers before seeking advice elsewhere.

Client Signature: _____ Date:_____

Laser Treatment Consent

I _____ (client) authorize Smooth Skin Centers laser technicians to perform laser treatments using the GentleYag, GentleLase, Smoothbeam, and/or ATV lasers. I authorize the following laser procedures to be treated (check all that apply).

___ Hair Removal
___ Red or Brown Spot Removal
___ Acne Reduction
___ Spider Veins Erasing
___ Skin Tightening or Wrinkle Reduction
___ Tattoo Removal
___ Scar Reduction
___ Other: _____

The Laser is a device that produces an intense but gentle burst of light. This light is absorbed by and causes selective heating of certain cells in the unwanted, targeted lesion(s). Lesions or hair follicles most commonly fade slowly over time as these destroyed cells are eliminated by normal body processes. The following is a list of possible risks and complications due to this (these) procedure(s): **Purpura** (red-purple discoloration, bruising); **Itching** (including hive-like response); **Herpes simplex virus activation**; **Burns, Blisters, Scabbing, Crusting, Skin Color and/or Textural Changes**; **Hyperpigmentation** (darkening of the skin; transient or long term); **Hypopigmentation** (lightening of the skin; transient, long term or possible permanent); and **Scarring** (rare, possibly permanent). My eyes will be covered with laser specific safety eyewear to protect them from the intense light. I will keep my eyes closed and will not attempt to remove the eye protection during treatment.

A topical anesthetic is usually not necessary. My provider or I may elect to use a form of topical anesthesia to reduce any discomfort during the procedure. A cryogen spray skin cooling device may be used during the procedure to decrease discomfort and protect the skin. All anesthesia options and risks will be discussed with me in advance. I will be given complete instructions regarding after care of the treated area. It is important to follow aftercare instructions carefully to minimize the chance of incomplete healing, skin textural changes or scarring. Sun avoidance and/or use of a sun block are highly recommended. Tanning without sunscreen should be avoided for a minimum of seven days prior to any laser treatment.

I agree to all that are checked or otherwise acknowledged or indicated:

- I have provided my past and current medical history and medications and that it is my responsibility to keep Smooth Skin Centers' Inc. aware of any changes to my medical history and medication usage.
- I am not pregnant (female patients) and shall notify Smooth Skin Centers if that changes.
- If I am using prescription-strength acne medication, I have my doctor's permission to receive treatments.
- I understand I cannot be treated if I have an active outbreak of any viral infection.
- I understand that payment is due at the time of the treatment and that no refunds or transfers are given.
- I consent to the taking of photographs during the course of my laser therapy for healthcare and/or medical or marketing purposes. My full name will not be used to identify these photographs.

- I agree to avoid getting chemical peels or other laser/cosmetic treatments for at least two weeks before or after my laser treatments at Smooth Skin Centers without prior approval from a Smooth Skin Centers' laser technician or injector.
- I recognize that the practice of laser medicine is not an exact science and acknowledge that no guarantees have been made to me concerning the results of such procedures and thus no monetary refunds will be issued to me on any previous or future treatments.
- I understand that if I need to cancel or reschedule my laser appointment, I need to do so by noon the day before my appointment. If I cancel this appointment past this cut off time, I am aware I will need to pay a reschedule charge of at least $35 per treatment or per 15-minute block I was scheduled.
- I understand that if I cancel my appointment or treatment areas the same day of my scheduled appointment or if the technician is unable to do the laser treatment because of my recent sun exposure or other reasons, that I will still be responsible for paying for my treatments.
- I understand that complete clearing may not be possible and will depend upon the type, age and color of the lesion, amount of hair or other considerations, and that multiple treatments may be needed before seeing any results or for the best results.
- Alternative methods of treating this condition have been discussed with me such that I may assess the risks and benefits of these alternative treatment methods.
- I have been given the opportunity to ask questions about the procedure(s). My questions have been answered, and I understand the information given to me.
- Contraindications to the performance of this procedure(s) have been discussed in detail with me, and I understand that my skin's condition may actually temporarily worsen as a result of this treatment.
- I have received the after-care instructions provided for by Smooth Skin Centers, Inc. and I understand it is my responsibility to follow these instructions, and that my failure to adhere to these recommendations may result in complications and contraindications for which I am fully responsible, and for which I will not and cannot hold Smooth Skin Centers or its staff responsible.
- I understand that any side effects may last 7-14 days or longer and should resolve within several days, but may last longer. Discomfort may be treated with products and methods we suggest.
- I understand that immediately following the laser treatment temporary side effects may occur, including but not limited to: redness, swelling, blistering, burns, itching, discomfort, bruising and discoloration (hyper- and hypo-pigmentation), and that scarring, while rare, is also possible. I agree to notify Smooth Skin Centers if any of these side effects occur.
- I agree that if I experience alarm or concern regarding my treatment that I need to immediately both notify and be physically seen by Smooth Skin Centers prior to being seen by any other health care provider in order to get direction and feedback. If I chose to seek advice elsewhere or self-treat any side effects prior to being seen by Smooth Skin Centers or if I chose to not follow the recommendations provided I accept 100% responsibility for any effect or contraindication that may or may not occur.

I have read and understood all information presented to me before signing this consent form and hereby release Smooth Skin Centers, Inc., its staff and medical director from all liabilities associated with the above indicated procedures.

Client Signature:_____ Date: _____

Parent/Legal Guardian
(if Client is under 18 years old): _____ Date: _____

Laser Technician: _____ Date: _____

Acknowledgment of Missed Appointment Policy

We're happy to have you as a client. Really! And we do everything we can to help you achieve the results you want. To help you stay on schedule, we will send out automated text and email reminders TWO days before your appointment. If you need to cancel or reschedule your LASER appointment, please do so by noon the day before your scheduled appointment. If you have to cancel your BOTOX or JUVEDERM appointment, please do so by 3:00 pm TWO DAYS prior to your scheduled appointment. This gives us a chance to rebook the time we had reserved for you. Should you cancel your appointment past this cut-off time, you will be assessed a reschedule charge of at least $35 per treatment or per 15-minute block.

If you cancel your appointment the same day you are scheduled, you will be expected to pay for all the treatments you are scheduled for. Once you've arrived for your appointment, you will be expected to pay for all the treatments you are scheduled for, even if you decide not to do the treatments or have sun exposure or have had other services that could cause negative side effects in conjunction with our service. If you are late to your appointment and we don't have enough time to do what you had scheduled, you will be expected to pay for all the treatments you are schedule for, even if we don't have time to do the treatments.

Authorization: *By signing below, I authorize Smooth Skin Centers to charge my credit card for the cancellation fees explained in the above paragraphs. I understand I will not receive further treatments if I have an unpaid balance as a result of not providing a credit card number or if Smooth Skin Centers is unable to process a missed appointment charge.*

Today's Date _____

Your Name (please print) _____

Client Signature: _____

Email address: _____

Card Number: __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __

Expiration date _ _ / _ _ _ _ Code on back __ __ __ Zip Code __ __ __ __ __

This information is kept strictly confidential.

If you do not want to provide your credit card number, we ask that you please read and sign this form and return it to us. Your signature acknowledges you are aware of and agree with and give permission to these described policies. Thanks!