Westchase Medspa
Where aging is optional

6928 W. Linebaugh Ave. Suit 102, Tampa, FL 33625
(813) 749-7143
(813) 264-9262
www.westchasespa.com

Informed Consent – Lam Probe

Patient Name: _____ Treatment Areas: _____

Westchase Medspa has explained to me that the Lam Probe processes are popular and effective for the cosmetic care of many minor superficial skin irregularities that professional aesthetic therapists encounter on a daily basis. I consent to have the Lam Probe utilized on me for the purpose of the cosmetic treatment (skin lesion) _____ in the following area(s) _____
_____.

As with any cosmetic procedure, the goal is for the esthetic improvement not perfection. Risks associated with the Lam Probe are minimal and may include burns/scabbing, skin discoloration, and scarring, thus it is extremely important to follow home care advice to minimize these risks. I attest that I am unaware of any underlying conditions (e.g. skin cancer or skin diseases). I understand that several factors including skin color, age, ethnicity, hormonal activity, inherited conditions, and other influences may decrease effectiveness of cosmetic treatments.

Please read and initial the following acceptances.

_____ I understand that the Lam Probe treatment uses a very fine disposable needle but does not break the skin. A small amount of electrical current in the form of radio frequency is then applied through this needle to the point of treatment to improve skin lesions. I have been specifically advised that this office has implemented infection control procedures.

_____ I confirm that I have not taken Accutane for at least one year.

_____ I consent to the taking of photographs during the course of my Lam Probe treatment for use in my chart and promotional material.

_____ I certify that I have been fully informed of the nature and purpose of the procedure, expected outcome and possible complications and I understand that no guarantee can be given as to the final result obtained.

_____ I understand compliance with treatment guidelines is crucial for optimum results. I have read and understood all information presented to me before signing this consent. I understand and consent to the policy that I will be charged $35 for any appointments cancelled with less than 24 hours' notice.

Many factors determine the number and the length of treatment required. The closer you adhere to your treatment schedule, the more effective your treatment will be.

Lamprobe After Care

After treatment with the Lamprobe, the areas treated may feel irritated. Redness and scabbing may also occur. Please follow the below protocols for home care:

- DO NOT PICK at the areas treated even if scabbing occurs, because prematurely removing the scabs may lead to infection, hyper/hypopigmentation, or scarring.
- When cleansing the area, avoid using any products other than the recommended VisaoMD. Pat the area dry instead of rubbing to prevent removal of the scab.
- If instructed to do so, apply anti-biotic ointment and/or VisaoMD Recover to the area multiple times per day to keep the area moist.
- Use provider's recommended physical sunblock as recommended.
- Discuss with your provider before using any other skin care products other than the cleanser and sunblock.
- You may continue all of your other medical grade skincare products, but do not put anything potentially irritating (retinol, acids, exfoliants) directly on the treated spot/lesion/area until instructed to do so.

Contact our office if you have any questions, concerns, problems at (813) 749-7143.

I understand the above instructions. I understand the risks and signs of side effects and complications such as severe redness, swelling, blistering, burns, ulcers, pain, or signs of infection and I will call the office if I have any questions or concerns.

Printed name:_____ Signature:_____ Date:_____

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Confidential Patient Information

Name:_____ Date of Birth:_____ Age:_____ Sex: ☐ Male ☐ Female

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

Home phone:_____ Cell phone: _____ Email Address:_____

Please check if you are affected by or have any of the following:

- ☐ Asthma
- ☐ Cardiac Problems D
- ☐ Depression/Anxiety
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fever Blister
- ☐ Headaches-chronic
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hysterectomy
- ☐ Immune Disorders
- ☐ Lupus
- ☐ Metal bone
- ☐ Pins or plates
- ☐ Pacemaker
- ☐ Sinus Problems
- ☐ Skin Diseases-other
- ☐ Urinary or Kidney Problems

Are you... ☐ Pregnant? ☐ Trying to get Pregnant? ☐ Breastfeeding? ☐ Lactating?

Please choose the best match for yourself

What is your hereditary background? _____

Natural Eye Color:_____ Natural Hair Color:_____ Skin tone:_____

Do you consider your skin (Check all that apply):

- ☐ Normal
- ☐ Dry
- ☐ Dark Circles
- ☐ Oily
- ☐ Acne
- ☐ Comedones/blackheads
- ☐ Milia
- ☐ Cysts
- ☐ Acne-Scarred
- ☐ Large Pores
- ☐ Small Pores
- ☐ Rosacea
- ☐ Eczema
- ☐ Freckled
- ☐ Melasma
- ☐ Hyperpigmentation
- ☐ Hypopigmentation
- ☐ Uneven/blotchy
- ☐ Patchy Dryness
- ☐ Sallow
- ☐ Psoriasis
- ☐ Dehydrated/lacking Moisture
- ☐ Telangiectasia/broken Surface
- ☐ Capillaries
- ☐ Breakouts

Do you consider your skin: ☐ Sensitive ☐ Resilient ☐ Unsure

Do you have any allergies to medications? (Please list all allergies on back of page.)

Do you have allergies to cosmetics, foods, or drugs?	☐ Yes	☐ No	Have you had skin cancer?	☐ Yes	☐ No
Do you have allergies to aspirin?	☐ Yes	☐ No	Have you ever or are you now using Accutane?	☐ Yes	☐ No
Do you use or receive depilatories or waxing?	☐ Yes	☐ No	Are you sensitive to alcohol based products?	☐ Yes	☐ No
Have you had collagen, Botox or other dermal filler injections?	☐ Yes	☐ No	Do you use sunscreen daily?	☐ Yes	☐ No
Are you presently under a physician's care for any skin condition?	☐ Yes	☐ No	Are you taking birth control or hormone replacements?	☐ Yes	☐ No

If yes, please explain:_____

Do you have sensitive to any of the following? ☐ Yes ☐ No

☐ Milk ☐ Apples ☐ Citrus ☐ Grapes ☐ Aloe vera ☐ Aspirin ☐ Perfumes ☐ Latex ☐ Hydroquinone ☐ Mushrooms

Do you experience cold sores/fever blisters?	☐ Yes	☐ No	Do you use tanning beds?	☐ Yes	☐ No
Have you recently had facial surgery?	☐ Yes	☐ No			

If yes, what type of surgery?_____

Have you recently had laser resurfacing? ☐ Yes ☐ No

If yes, what type of treatments and when?_____

Do you smoke, use tobacco or live with a smoker?	☐ Yes	☐ No	Do you often experience stress?	☐ Yes	☐ No
Do you have permanent make-up?	☐ Yes	☐ No	Do you wear contact lenses?	☐ Yes	☐ No
Have you had professional skin care in the past?	☐ Yes	☐ No	Do you participate in vigorous exercise or sports?	☐ Yes	☐ No

What skin care products do you currently use? _____

How many ounces of water do you drink daily? _____

_____ _____

Signature Date

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Client Treatment Consent and Release

I acknowledge that beauty treatments, the practice of skin care, and the practice of massage, including, but not limited to,microablation, microdermabrasion, waxing, electrolysis, facial toning, permanent cosmetics, body treatments, ionization, laser treatments, tattoo removal, vein treatments, brown spot removal, BOTOX, Collagen, Dermal Fillers, Sclerotherapy, Mesotherapy, Dermaplaning, 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 inorder 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, and change in skin pigmentation, allergic reaction, muscle damage, and increased hair growth. I understand that even though precautions may be taken in my treatment, 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 insured's, as well as any officers, 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 form any medications, previous complications, or 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.

Date: _____

Client Signature: _____ Printed Name: _____

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

Date: _____

Client Signature: _____ Printed Name: _____

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HIPAA Consent

I give Westchase Medspa my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care options like quality reviews. I give Westchase Medspa my consent to use or disclose my protected health information in order to obtain payment for services and/or product.

I have been informed that I may review Westchase Medspa's Notice Of Privacy Practices (for a more complete description on uses and disclosures) before signing this consent.

I understand that Westchase Medspa has the right to change their privacy practices and that I may obtain any revised notices at the clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Westchase Medspa is not required to agree to the request. If Westchase Medspa agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Patient, parent or legal guardian:_____

Signature: _____ Date:_____

If signed by patient representative, state relationship to patient:_____

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Patient Treatment Record

Date:_____ Area Treated:_____ Settings:_____ Tech (Initial):_____
Notes:_____

Date:_____ Area Treated:_____ Settings:_____ Tech (Initial):_____
Notes:_____

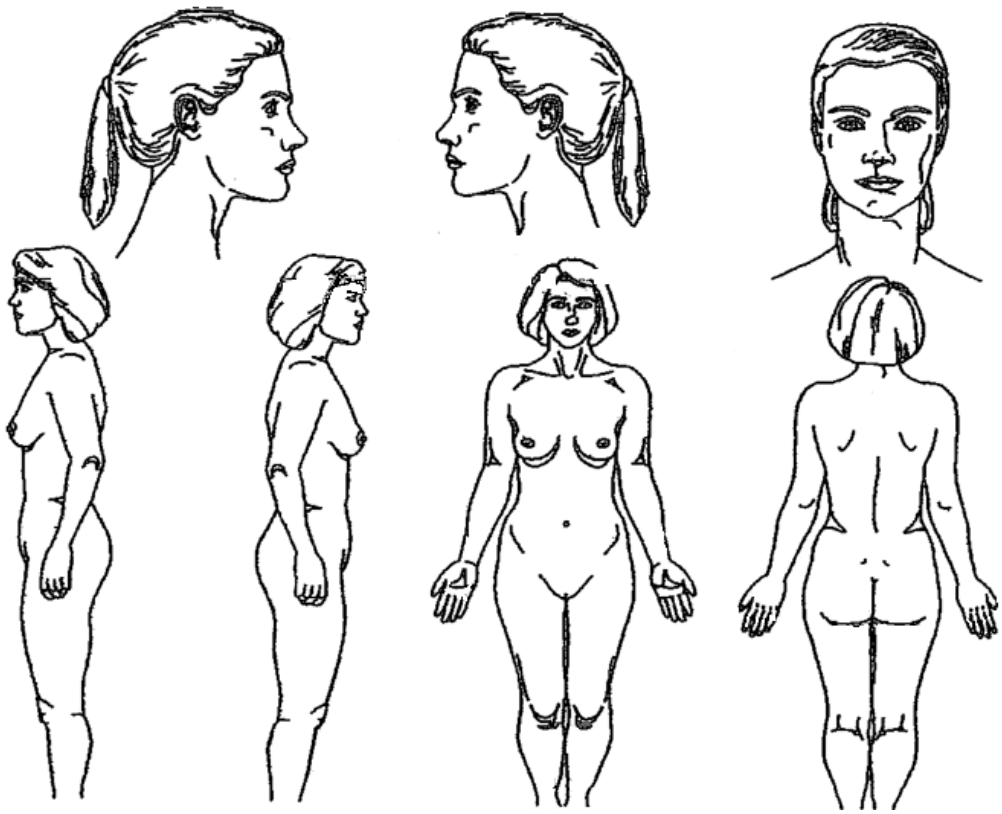
Date:_____ Area Treated:_____ Settings:_____ Tech (Initial):_____
Notes:_____

Date:_____ Area Treated:_____ Settings:_____ Tech (Initial):_____
Notes:_____

Date:_____ Area Treated:_____ Settings:_____ Tech (Initial):_____
Notes:_____

Date:_____ Area Treated:_____ Settings:_____ Tech (Initial):_____
Notes:_____

Date:_____ Area Treated:_____ Settings:_____ Tech (Initial):_____
Notes:_____



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