RenoVation
Dr. Virden's Medical Spa

SKINCARE AND LASER TERATMENT CONSENT

Proposed Treatment
A facial starts with an analysis of the skin to look for general skin type and any congestion. Once the analysis is complete, the proper facial treatments will be performed.
Initials: _____

I realize that the practice of skincare treatments including microdermabrasion, peels, broadband light therapy, IPL hair removal, microlaserpeels, Skintyte and profractional treatments etc., is not an exact science and no specific guarantees can or have been made concerning the expected result. I understand some clients experience more change and improvement that others. In virtually all cases, multiple treatments are required in order to realize a difference.
Initials: _____

During your treatment, safe exfoliating products may be used to improve the appearance of your skin. . If you have the Herpes Simplex Virus–Type 1, please note exfoliating treatments may cause an outbreak. If you have skin irritation, visible cold sores or are sunburned, you may be asked to reschedule your appointment.
Initials: _____

After your facial treatment:
- Do not use active products for a full 24 hours after your treatment. Avoid the sun and apply sunscreen as directed.
- You may experience flaking, sensitivity and/or light scabbing on extracted comedones, which is normal and will subside within a few days to reveal improved skin.
Initials: _____

Please indicate your skin type:

Normal/Dry_____ Dry_____ Oily_____

How often do you wash your face? _____

How does your skin feel at the end of the day?
_____

Have you ever had a facial? Yes_____ No_____
If yes, when? _____

What facial products do you use?
_____
_____

Are you currently on any medication? Yes__ No__

If yes, what are they? _____
_____

Have you suffered from acne? Yes__ No__

Are you using Retin-A? Yes____ No____
If yes, what strength? _____% How long? _____

Are you using Accutane? Yes__ No__

Have you had a cosmetic peel before? Yes__No__
If yes, when? _____

Are you currently pregnant? Yes__ No__

Are you taking oral contraceptives? Yes__ No__

Do you currently take hormones? Yes__ No__

I understand that the following risks and hazards may occur in connection with any particular treatment, including but not limited to: unsatisfactory results, poor healing, discomfort, nerve damage, scarring, redness, blistering, infection, change in skin pigmentation and increased hair growth. I understand that even though precautions may be taken in my treatment, not all risks can be known in advance.
Initials: _____

Cost/Fees
Payment for this cosmetic procedure is my responsibility. I understand that there will be an additional fee if I should want/need maintenance or follow-up visits.
Initials: _____

I understand that if I decide to purchase a package or series of skincare treatments, the total price of the package must be paid before or after your first treatment in the series. Failure to do so will subject you to the single treatment price.
Initials: _____

I have read and fully understand this consent and all of my questions have been answered by the Renovation Medical Spa associates. I accept the risks and complications of the procedure.
Initials: _____

I agree not to hold Renovation Medical Spa or any of its representatives responsible for any adverse effects resulting from the Sciton Joule and any treatments it performs.
Initials: _____

_____

Patient Signature **Date**

_____

Patient Name (Print) **Date**

_____

Witness Signature **Date**