CB SKINCARE

MEDICAL HISTORY AND CONSENT

Full Name:

_____

Date: _____ Email: _____

Phone: _____ Address:

_____

How did you hear about CB Skincare?_____

Current Medications (Please List) _____

_____

Have you taken Accutane within the last year/ Y/N_____

Allergies (Please List)_____

_____

Please Read Carefully - Have you had or do you currently have any of the following? Indicate with a (X)

__Cancer
–- Contact Lenses
__ Diabetes
__ Hypoglycemia
__Tattoo Permanent Makeup
__ Heart Condition
__ Hepatitis
__Keloid Scars
__Thyroid Disease
__Botox Treatment
__ Chemical Peels
__ Laser Resurfacing
__ Previous Plasma Pen Treatment
__ Pacemaker

__Cold Sores
__ Dermatitis/ Eczema
__ Latex Sensitivity/Allergy
__ Epilepsy
__ High or Low Blood Pressure
__ Hemophilia
__ HIV/Aids
__ Problems with Healing
__ Iron Deficient/Anemic
__ Injectable Fillers
__ Glycolic Acid Peels
__ Pregnant or Currently Nursing
__ Cosmetic Surgery

If you suffer from any of the above, it is important that you notify your technician so that they can take the necessary precautions to ensure you receive the best treatment and avoid any risk to your health. In some cases treatment may be deemed unsuitable and denied .

Additional Notes:_____

Please read carefully and initial where indicated. Ensure all points below have been discussed with the technician. You are signing to state that you understand these terms and waive all liability.

1. *I acknowledge that any information given by me is true to the best of my knowledge and the present condition of the area has been treat or will be treated is stated on this record. I fully understand that CB Skincare services only provides beauty services. There is no medical treatment involved. Plasma Pen Treatment is an art and not an exact science and cannot guarantee an exact shrinkage result due to individual skin elasticity and healing process (Initial Here) ____*
2. *I understand that I may be required to return for additional treatment before the overall procedure is deemed complete. This depends entirely on size of area to be treatment, severity of concern and desired results. The payment for any additional work (if applicable) will be agreed prior to the treatment commencing. Depending upon the area of treatment, additional treatments cannot be performed until after 6-8 weeks from the initial treatment date to allow sufficient healing time. (Initial Here) _____*
3. *I realize that with any beauty services there may be certain risks which must be understood. I will be fully responsible for any and all results which may arise from these beauty services. I do hereby agree to hold CB Skincare, Amanda Cotton, Dermapro Canada Inc, their agents and employees free from any and all claims or suits for damage, for injuries or complications resulting from any beauty service provided by Amanda Cotton, CB Skincare.*
4. *I understand that any spot removal / skin revision work performed may result in slight scarring and or loss (or gain) of natural skin pigment. (Initial Here) _____*
5. *The skin type of every client is different and the healing process may lead to some discolouration of the skin. Diamond Dermabrasion may be advised after the healing process is complete. (Initial Here) ___*
6. *I understand that the taking of before and after photographs of the procedure is a condition of such procedure. I grant permission for the use of the photographs or electronic media images as identified in any presentation of all kinds. (Initial Here) ___*
7. *I have received pre and post procedure instructions with the care kit and will strictly adhere to them. I understand that my failure to do so may jeopardize my chances for a successful procedure outcome. (Initial here) ___*
8. *I understand the importance of my accurate and complete medical history. I understand that withholding any medical information may be detrimental to my health and safety during and after the procedure. I understand that if there are any changes in my medial history it is my responsibility to inform the technician, (Initial Here) ___*

9. *I am aware that any skin altering procedures such as Laser Treatments, plastic surgery, implants, injectables and weight gain or loss may alter the treamtnents look and results. (Initial Here) ____*
10. *I understand that if I wear eyelash extensions they must be removed prior to treatment and NOT replaced for a period of 8 weeks and after the follow up treatments have been taken. (Initial Here) ___*

I the client agree with all points listed and discussed, and wish to proceed as recorded. I participated fully in the decision for the selected area or areas intended for my Plasma Pen Treatment. I certify I have read carefully and initialed the above paragraphs. I have had it explained to my understanding therefore consent to this procedure. I accept full responsibility to receive this treatment.

Clients Full Name (Printed) _____
Client Signature _____. Date: _____

Treatment Agreement

I, the trained and certified technician, confirm I have checked all the paperwork including consent forms and medical history. I have discussed all the procedure points with my client and they understand all elements of the Plasma Pen Fibroblast Skin Tightening Treatment. Aftercare advice has been verbally presented to the client and written instructions will be provided.

Technician Signature: _____ Date: _____

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