OC Plasma Fibroblast - Medical History and Consent

Full Name: _____
Date:_____
Email:_____
Phone:(____)_____
Address:_____
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 YES with an (X)

_____Cancer.
_____Cold Sores
_____Contact Lenses
_____Dermatitis / Eczema
_____Diabetes
_____Latex Sensitivity / Allergy
_____Hypoglycemia
_____Epilepsy
_____Tattoo / Permanent makeup
_____Iron deficient / Anemic
_____Injectable Fillers If so, when _____
_____Laser Resurfacing
_____Plasma Pen Treatment
_____Melasma
_____Cosmetic Surgery
_____High or Low Blood Pressure
_____Heart Condition
_____Hemophilia
_____Hepatitis
_____Insulin dependent
_____HIV / Aids
_____Keloid Scars
_____Problems with Healing
_____Thyroid Disease
_____Botox Treatment If yes when
_____Chemical peels
_____Pregnant / Nursing
_____Hyperpigmentation
_____Pacemaker
_____Electrical implant with slow release medication
_____Lash Extensions

* If you suffer from any of the above, it is important that you notify your technician so that they can take the necessary precaution to ensure you receive the best treatment to avoid any risks to your health.
Additional Notes:

_____

_____

PLEASE READ CAREFULLY AND INITIAL / SIGN WHERE INDICATED.

Ensure all points below have been discussed with the technician. You are signing to state that you understand and accept these terms.

1. I acknowledge that any information contributed by me is true, to the best of my knowledge and that the present condition of the area that has been treated or will be treated is stated on this record. I fully understand that Tara Novelich of OC Plasma Fibroblast provides beauty services; There is no medical treatment involved. Plasma Pen and/or Jet Plasma Treatment is an art - not an exact science - and cannot guarantee an exact shrinkage result due to skin elasticity and individuality which includes client”s health, genetics, lifestyle factors and following proper after care. (Initial Here)_____

2. I understand that Jet Plasma requires sessions, minimum 4 suggested for best results and that I may be required to return for additional treatments before the overall procedure is deemed complete. 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 6-8 weeks after 8 sessions in the same area to allow sufficient healing time. (Initial Here)_____

3. I realize that with any beauty service 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 Tara Novelich of OC Plasma Fibroblast,their affiliates, and employees/students free from any and all claims or suits for damage, for injuries or complications resulting from any beauty services provided by Tara Novelich. I understand that any spot removals / skin revision work performed may result in loss or gain of natural skin pigment.
Initial Here)_____

4. The skin type of every client is different and although Jet is safe for all Fitzpatrick, it is important you follow our aftercare instructions. Additional sessions may be advised, after the healing process is complete. (Initial Here)_____

5. I understand that taking before and after photographs of the said procedures is a requirement 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)_____

6. I have received pre and post procedure instructions and will strictly adhere to them. I understand that my failure to do so may jeopardize my chances for a successful outcome. (Initial Here)_____

7. 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 is any change in my medical history it is my responsibility to inform the technician. (Initial Here)_____

8. I am aware that any skin altering procedures such as Laser treatments, plastic surgery, implants, injectables and weight gain or loss may alter the treatments look. (Initial Here)_____

9. The following are Contraindications in receiving the Jet Plasma Pen Treatment:
   - Pacemaker
   - Pregnancy
   - Hypersensitive
   - Cancerous Lesions
   - Implanted Neurostimulator
   - Any Electrical Implanted Device or Implanted Slow Medication Release.

I certify that I do not possess any of the contraindications listed above. (Initial Here)_____

I, the client, agree with all points listed and discussed, and wish to proceed as recorded with procedure with Tara Novelich of OC Plasma Fibroblast. I participated fully in the decision for the selected area or areas intended for my Jet Plasma Pen Treatment. I certify I have read and initialed the above paragraphs. I have had it explained to my understanding therefore I consent to this procedure. I accept full responsibility for the decision to receive this treatment and do not hold Tara Noelich of OC Plasma Fibroblast responsible for any adverse reaction.

Client's Full Name
(PRINTED):_____

Client Signature:_____
Date(M/D/Y):_____

Treatment Agreement
I, Tara Novelich of OC Plasma Fibroblast confirms I have checked all paperwork including consent forms and medical history, I have discussed all procedure points with my client and they understand all elements of the Jet Plasma Pen Treatment.
Aftercare advice has been verbally and electronically presented to the client and written instructions will be provided.

Technician Signature: _____
Date: (M/D/Y) _____