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GentleYag Skin Tightening / Vein Treatment Consent Form

Date: _______________

Name: ____

Address: ____

____

Date of Birth: _______________ Age: _______________ ☐ Female ☐ Male

Contact Phone Numbers:

(H): _______________________ (W): ______________________ (C): ______________________

Are You pregnant? ☐ Yes ☐ No

Allergies: ____

Are you currently taking any medications?

(Please list if any, Accutane, Aspirin, Antiviral, Coumadin, Photosensitivity drugs such as St. John's Wort)

____

Present Illnesses:

____

History of keloids / hypertrophic scars:

____

Other / Tanning history:

____

Area(s) to be treated:

____

Recommendations:

****After Reviewing the recommendations, please have client initial each item****

1. _____ Discuss client expectations: understand need for multiple treatments, after care, possible side effects, etc.
2. _____ Review in detail full treatment schedule process.
3. _____ Discuss sensation of the laser/DCD spray and the option for topical anesthetic.
4. _____ Discuss benefits of laser treatment and laser safety.
5. _____ Discuss cost (payment schedule, cost of multiple versus single payment per visit).

Comments:

____

____

____

Consent Agreement

I have been given the opportunity to ask questions and my questions have been answered to my satisfaction. I have been adequately informed of the risks, benefits and alternatives to this treatment and wish to proceed with the skin tightening or vein treatment.

Clients Signature: ____ Date: ____________

Clients Name ____

(Please Print)

Providers Signature: ____ Date: ____________

Providers Name ____

(Please Print)