

## INFORMED CONSENT FOR HYDRAFACIAL

HydraFacial is the only hydradermabrasion procedure that combines cleansing, exfoliation, extraction, hydration and antioxidant protection simultaneously, resulting in clearer, more beautiful skin with little-to-no downtime.

The treatment is soothing, moisturizing, non-invasive and generally non-irritating. As with most procedures, visible results from HydraFacial will vary from person to person.

### What to expect:

- Your skin may experience temporary irritation, tightness, or redness. These are all normal reactions that typically resolve within 72 hours depending on skin sensitivity.
- You may experience tingling and stinging in the treatment area. These sensations generally subside within a few hours.
- Patient experiences may vary. Some patients may experience a delayed onset of these symptoms.
- You will likely see results immediately after treatment and your skin may feel smooth and hydrated for one to four weeks with appropriate home care to maintain treatment results.
- The skin is more susceptible to sunburn/sun damage. Avoid excessive sun exposure and use a minimum of SPF 40 sunscreen. We recommend our medical grade sunblock such as: Elta MD or PCA Weightless.

### Do you have any of the following?

- |  |                           |                          |
|--|---------------------------|--------------------------|
| Active acne or infection _____   | <input type="radio"/> YES | <input type="radio"/> NO |
| Open lesion or cold sore _____   | <input type="radio"/> YES | <input type="radio"/> NO |
| An active infection in the treatment area _____  | <input type="radio"/> YES | <input type="radio"/> NO |
| Active sunburn _____   | <input type="radio"/> YES | <input type="radio"/> NO |
| Skin conditions such as eczema, dermatitis, or rashes _____                                  | <input type="radio"/> YES | <input type="radio"/> NO |
| An autoimmune disease such as lupus _____  | <input type="radio"/> YES | <input type="radio"/> NO |
| A viral concern such as HIV or hepatitis _____   | <input type="radio"/> YES | <input type="radio"/> NO |
| Anticoagulants Therapy _____   | <input type="radio"/> YES | <input type="radio"/> NO |
| Melanoma or lesions suspected of malignancy _____  | <input type="radio"/> YES | <input type="radio"/> NO |
| Pregnancy or lactation _____   | <input type="radio"/> YES | <input type="radio"/> NO |
| Neurological disorders such as epilepsy (LED Lights) _____                                   | <input type="radio"/> YES | <input type="radio"/> NO |
| Infection in the urinary system i.e. kidneys, bladder and urethra (Lymphatic drainage) _____ | <input type="radio"/> YES | <input type="radio"/> NO |
| Crohn's Disease (Lymphatic drainage) _____   | <input type="radio"/> YES | <input type="radio"/> NO |
| Hyperthyroidism (Lymphatic drainage) _____   | <input type="radio"/> YES | <input type="radio"/> NO |
| Deep Venous Thrombosis (Lymphatic drainage) _____  | <input type="radio"/> YES | <input type="radio"/> NO |
| Lymphedema (Lymphatic drainage) _____  | <input type="radio"/> YES | <input type="radio"/> NO |

### Have you recently?

- |  |                           |                          |
|--|---------------------------|--------------------------|
| • Used Accutane, topical medications or antibiotics _____      | <input type="radio"/> YES | <input type="radio"/> NO |
| • Had aesthetic fillers, injectables or laser treatments _____ | <input type="radio"/> YES | <input type="radio"/> NO |



## ACKNOWLEDGEMENT

- I will avoid the use of aggressive exfoliation, waxing, and products containing glycolic acids or retinols that are not part of the recommended take-home regimen in the treated areas for minimum 2 weeks pre- and post-treatment.
- Photos will be taken before and after the HydraFacial treatment. Photos will remain confidential in the patient file and will only be used for promotion or advertising purposes with the written consent of the patient
- The information provided has been explained to me and all my questions have been answered to my satisfaction. I have read the above information, and I give my consent to have the HydraFacial treatment by the staff at **Desert Medical Rejuvenation**.
- By signing below, I acknowledge that I have read the above information and give my consent to be treated with the HydraFacial System. I will alert the staff if there are any future changes to my medical history.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient Signature: \_\_\_\_\_  
Witness Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Witness Signature: \_\_\_\_\_  
Translator Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Translator Signature: \_\_\_\_\_  
Esthetician Name: Sabrina Cazares Date: \_\_\_\_\_  
Esthetician Signature: \_\_\_\_\_

### Continued Treatment Consent

Date: _____	Initials: _____
Date: _____	Initials: _____
Date: _____	Initials: _____
Date: _____	Initials: _____
Date: _____	Initials: _____
Date: _____	Initials: _____