REVIVE
MEDICAL SPA LLC

HydraFacial, MD Consent and Release Form

Please read carefully, complete, sign and date this form prior to your procedure

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ DOB: _____

❑ HydraFacial ❑ Blue/Red Light Therapy ❑ Lymphatic/Massage Therapy
❑ Microdermabrasion ❑ Wet Diamond (Medical Use Only)

SECTION 1: MEDICAL INFORMATION

Absolute Contraindications

❑ Yes ❑ No Accutane or other similar medication
❑ Yes ❑ No Autoimmune disease, HIV, lupus, hepatitis, scleroderma
❑ Yes ❑ No Active infection in the treatment area
❑ Yes ❑ No Melanoma or lesions suspected of malignancy
❑ Yes ❑ No Active Sunburn
❑ Yes ❑ No Pregnancy (medical-legal)
❑ Yes ❑ No Breastfeeding (medical-legal, may increase skin sensitivity & likelihood of PIH
❑ Yes ❑ No Epilepsy contraindicated for LED light therapy

Relative Contraindications

❑ Yes ❑ No Anticoagulants therapy (use lower settings)
❑ Yes ❑ No Very thin skin
❑ Yes ❑ No Other Aesthetic Treatments: Botox: wait 5-7 days; Fillers: wait 7-10 days; Peels: wait 30 days
❑ Yes ❑ No Laser Treatments: wait until lesions heal & swelling & redness is resolved

Other Concerns

❑ Yes ❑ No Keloids: avoid direct contact
❑ Yes ❑ No Rosacea, telangiectasia (lower vacuum)
❑ Yes ❑ No Unrealistic expectations

If you answered YES to any of the above questions, please explain:

_____

_____

Please list any known allergies:

_____

_____

Specify your areas of concern: (i.e. eyes, forehead, etc.):

_____

_____

SECTION 2: CLIENT CONSENT FORM
(initial each acknowledgment line below)

1. I acknowledge that my skin might experience temporary irritation, tightness, or redness, which usually dissipates within 72 hours depending on skin sensitivity. _____

2. I acknowledge that if I fail to use a minimal sunscreen (SPF 30) and follow the direction for use, I am more susceptible to sunburn, sun damage & hyperpigmentation. I should avoid excessive sun exposure especially between 10am-2pm. _____

3. I have disclosed my history of allergies above and I acknowledge that I may experience an allergic reaction. _____

4. I hereby agree to have the treatment performed and agree to follow all pre-and post-treatment instructions. _____

5. I acknowledge that I should avoid use of aggressive exfoliation, waxing, and products containing acids that are not part of the recommended take-home regimen in the treated areas for minimum 2 weeks pre- and post-treatment. _____

6. I acknowledge that I have answered all questions truthfully and completely. _____

7. I acknowledge that I should avoid use of Retin-A type products for a period of time recommended by my physician and /or skincare practitioner per and post the treatment. _____

8. I release Edge Systems, Dr. Lance Henry, management, and staff of Advanced Dermatology and Skin Cancer Center, PLLC and Revive Medical Spa, LLC from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products. _____

9. I consent to the use of my before, during and after facial procedure photographs for education, promotion or advertising purposes. My name will not be used to identify these photographs without my written approval. _____

By signing below, I certify that I have read and fully understood the contents of this consent form, and that the information I provided above are complete, accurate, and up-to-date to my knowledge.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____