CHRISTUS ST. VINCENT
PLASTIC SURGERY SPECIALISTS

CONSULTATION + RELEASE FORM

1631 Hospital Drive, Suite 150 | Santa Fe, NM 87505 | T (505) 913 4360 | F 505 984 0373

PLEASE READ CAREFULLY, COMPLETE, SIGN, AND DATE THIS FORM PRIOR TO TREATMENT

Name: _____ Phone: _____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

☐ HYDRAFACIAL® ☐ LED LIGHT THERAPY ☐ LYMPHATIC/MASSAGE THERAPY ☐ MICRODERMABRASION

SECTION 1: MEDICAL INFORMATION

YES	NO	ABSOLUTE CONTRAINDICATIONS
☐	☐	Accutane or other similar medication (in the past year)
☐	☐	Autoimmune disease, HIV, lupus, hepatitis, scleroderma
☐	☐	Active Infection in the treatment area
☐	☐	Melanoma or lesions suspected of malignancy
☐	☐	Active Sunburn
☐	☐	Pregnancy (medical-legal)
☐	☐	Breast feeding (medical-legal, may increase skin sensitivity of likelihood oh PIH)
☐	☐	Epilepsy Contraindicated for LED light therapy
		RELATIVE CONTRAINDICATIONS
☐	☐	Anticoagulants therapy (use lower settings)
☐	☐	Very thin skin
☐	☐	Other Aesthetic Treatments: Botox: wait 5-7days; Fillers: wait 7-10 days: Peels: wait 30 days
☐	☐	Laser Treatments: wait until lesions heal & swelling & redness is resolved
		OTHER CONCERNS
☐	☐	Keloids: avoid direct contact
☐	☐	Rosacea, telangiectasia (use lower vacuum)
☐	☐	Unrealistic expectations

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

_____

Please list any known allergies: _____

_____

SECTION 2: CLIENT CONSENT FORM *(Initial each acknowledgement 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 (SPF30) and follow the direction for use, I am more susceptible to sunburn, sun damage and hyperpigmentation. I should avoid excessive sun exposure, especially between 10 am–2 pm.

_____ 3. I have disclosed my history of allergies above and I acknowledge that if I am allergic to one or more of the ingredients in the products used. 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 have answered all questions truthfully and completely.

_____ 6. I release Edge Systems, and the management and staff of CSV Plastic Surgery Specialists from any and all liability associated with any injuries and /or current or future conditions resulting from the skin care procedure or products.

_____ 7. 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 provide above are complete, accurate, and up-to-date to my knowledge.

Client Signature: _____ Date: _____

Operator Signature: _____ Date: _____