172 W. Carmel Drive Carmel, IN 46032 Tel: (317)575-2737

INDY LASER CLIENT INFORMATION

Client Name_____

Address_____

City_____ Zip Code _____

Mobile Phone_____

Home Phone_____

Date of Birth_____ Body Hair Color_____

Email Address _____

Referral Source (Circle) - Sign – Money Mailer – Web Search – Miss Indiana – Pacers – Colts – Angie's List - Facebook – Twitter – Yelp – Radio - Friend/Family – Other

If Friend or Other, please specify_____

If Web Search, which did you use? – Google – Yahoo – Bing - Other

What service(s) are you interested in? (Circle)

Hair Removal - Tattoo Removal - Skin Tightening - Age/Sun Spots - Acne Scarring
Rosacea - Stretch Marks - DermaSweep - Microdermabrasion - Chemical Peels
Body Sculpting - Myofascial Release - Therapeutic Massage - Other

Area(s) to be treated_____

How are you currently treating the area? _____

Patient Signature_____Date_____

INDY LASER MEDICAL HISTORY AND PHYSICAL

Client Name_____
Date_____

Medications_____□ None
_____
_____

Allergies_____□ None
_____
_____

Recent use of Accutane, Retin-A or Bleaching Agent _____□ No
If yes, when? _____

What skin care products are you currently using?_____
_____

Previous Laser Use____□ No - If yes, result? _____
When was your last treatment? _____
How many treatments have you had? _____

□ Herpes	□ Keloids	□ Pacemaker	□ Seizures
□ HIV	□ Lupus	□ Poor healing	□ Light Sensitivity
□ HPV	□ Hepatitis	□ PCOS	□ Thyroid Disorders
□ Hives	□ Medical Implants	□ Pregnant	□ Vitiligo
□ Immunosuppression	□ Melanoma	□ Scleroderma	□ None

Do you smoke? □ Yes □ No □ Quit
Have you had any recent sun exposure? □ Yes □ No When? _____
Have you used any self tan products? □ Yes □ No When? _____
Have you recently tweezed or waxed? □ Yes □ No When? _____
Do you have any tattoos/permanent make-up? □ Yes □ No Where? _____
If so, have you used any methods to remove it? □ Yes □ No Type? _____

If information in medical or physical history were to change during course of treatments, please advise technician prior to continuing treatments.

Patient Signature_____Date_____

…….. *To Be Completed By Authorized Personnel* ……

Fitzpatrick Scale

I II III IV V VI

Notes_____
_____
_____

Authorized Signature_____

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INDY LASER HAIR REMOVAL CONSENT FORM

I, _____, authorize Indy Laser and its technicians to perform Indy Laser Hair Removal treatments on me. I understand that the procedure is purely voluntary and multiple treatments may be necessary.

The Candela GentleLASE and GentleYAG are devices that produce an intense, but gentle burst of light that fragments the targeted area with selective destruction without harming the surrounding tissue. To protect my eyes from the intense light, I will be wearing laser protective glasses.

I understand that complications are rare, but possible. I have been informed that common side effects following treatment include temporary redness, mild "sunburn" like effects, bumps, blistering, purpura, hypo pigmentation, hyper pigmentation. Usually, if these occur, they are temporary and can resolve in a few days or weeks, in extremely rare cases, may last from 6- 12 months or longer. In addition, freckles may lighten and/or temporarily or permanently disappear in treated areas. Other potential risks include, but are not limited to crusting, itching, and failure to achieve the desired result.

I understand that my cooperation post treatment will help to reduce the probability of the above stated complications. I am fully aware that improper care of the treated area may increase the chance of scarring, hyperpigmentation, or skin textural changes. The treated area can take 6 -12 months or longer to heal. This has been discussed with me.

I understand the goal of this procedure, as in any cosmetic procedure, is improvement not perfection. I understand my result might not be perfect and there may be more treatments necessary than I anticipated. The number of treatments is dependent on several factors including skin color, tan and hair color. The laser can cause a reduction in hair or cause profound hair growth delay, but results definitely vary from person to person.

ACKNOWLEDGMENT:

I have read and understood all the information presented to me before signing this consent. I understand the procedure and accept the risks. I release Indy Laser and its technicians from liability associated with the Indy Laser Hair Removal procedure.

Signed: _____Date:_____
(Patient or person legally authorized to consent for patient)

Witness: _____

Version 9/14

Name_____
(Please Print)

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION
(HIPAA)

I authorize Indy Laser to make email, text or phone reminders prior to my appointments at Indy Laser at the contact information provided to Indy Laser.

Sign_____Date_____

If you wish us to share any of your treatment or appointment related information please complete the section below.

This HIPAA form requests you to advise: (A) *to whom we may disclose information* (B) *the reason for disclosure,* and (C) *the information to be disclosed.* However, to further protect your right to privacy, Indy Laser *will not use or disclose* health information to family members, Doctors, Insurance Companies, Health Insurance Companies or to any other Entities *without a current written authorization at the time the information is to be released.*

Indy Laser may discuss your health and/or treatment with/will provide your information to:

A. I,_____, hereby authorize the disclosure of my health/treatment information from my records to:
   Name: _____
   Address: _____
   City/State/Zip: _____

B. The purpose/reason for this disclosure is:_____
   _____

C. The information I authorize to be disclosed from my health/treatment record: (initial appropriate box(es))

_____Entire record _____Visit Notes _____Health and Physical

_____Medical list _____Problem list _____Billing

Only information related to: (specify)
_____
_____

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Indy Laser Late and Cancellation Policy

As we continue to grow and book out appointments, we have the need to adopt a new cancellation and late policy. We need to have at least 24 hours notice of the need to cancel or reschedule an appointment. There will be a $25 fee for any missed appointment, being late more than 10 minutes or more for an appointment, as well as not giving a 24 hour notice of cancellation or rescheduling. If you do show up more the 10 minutes late we may not be able to treat you. This fee will be required to be paid before any additional treatments will be performed. We understand emergencies will happen and this policy is not being enforced for extra revenue. It is being enforced because it is unfair to other clients who would like to have your unused appointment slot. A fee can be waived for an emergency and this fee can only be waived one time.

Signed: _____Date:_____
(Patient or person legally authorized to consent for patient)

Indy Laser Hair Removal
Treatment Consent Form

I agree and confirm I have not had any new sun or tanning bed exposure in the last 2(two) weeks, nor do I expect to have any in the next 2(two) weeks following my appointment. I also confirm I do not have any residual tan that will interfere with my treatment. I have not started any new medications or antibiotics in the last 2(two) weeks. I am not currently pregnant and have not had any changes in my health since my last treatment. I am refraining from skin care products that contain acids such as lactic, glycolic, benzyl peroxide, salicylic, alpha-hydroxy, retin-a or prescription acne medications. I understand that not disclosing the above information may cause complications with my treatments such as burning, blistering, crusting, hyper or hypopigmentation. These complications can be temporary lasting several months or in some instances become permanent. I understand my technician has the right to refuse any service to me for any of the above reasons.

I have read and understand all the information presented to me before signing this consent. I release Indy laser and its technicians from liability associated with the treatments I am requesting them to perform.

Signed: ______________________________Date: ___________ Current Phone: (____)____________Home/Cell/Work

(Patient or person legally authorized to consent for patient)

Signed: ______________________________Date: ___________ Current Phone: (____)____________Home/Cell/Work

(Patient or person legally authorized to consent for patient)

Signed: ______________________________Date: ___________ Current Phone: (____)____________Home/Cell/Work

(Patient or person legally authorized to consent for patient)

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(Patient or person legally authorized to consent for patient)

Signed: ______________________________Date: ___________ Current Phone: (____)____________Home/Cell/Work

(Patient or person legally authorized to consent for patient)

Indy Laser Hair Removal
Aftercare Instructions

1. Immediately after the treatments, there could be redness and bumps at the treatment area, which may last up to 2 hours or longer. It is normal for the treated area to feel like sunburn for a few hours. You should use a cold compress if needed. If any crusting, apply antibiotic cream or Aquaphor. Darker pigmented people may have more discomfort than lighter skin people and may require the aloe vera gel or an antibiotic ointment longer.

2. Makeup may be used after the treatment, unless there is epidermal blistering. It is recommended to use new makeup to reduce the possibility of infection. Just make sure that you have moisturizer on under your makeup. In fact, moisturizer will help the dead hair exfoliate from the follicle, so use moisturizer frequently and freely on the treated area. Any moisturizer without alpha-hydroxy acids will work.

3. Avoid sun exposure 2 months before and after treatments to reduce the chance of dark or light spots and to maximize results. Use sunscreen SPF 30 or higher at all times throughout the treatment and for 1-2 months following.

4. Avoid picking or scratching the treated skin. DO NOT USE waxing, tweezing or threading on the treated area during the course of your laser treatments, as it will prevent you from achieving your best results.

5. You may shower after the laser treatments, and use soap, deodorant, etc. The treated area may be washed gently with a mild soap. Skin should be patted dry and NOT rubbed.

6. Anywhere from 5-30 days after the treatment, shedding of the hair may occur and this may appear as new hair growth. This is not new hair growth, but dead hair pushing its way out of the follicle. You can help the hair exfoliate by washing or wiping with a washcloth.

7. Hair re-growth occurs at different rates on different areas of the body. New hair growth will not occur for at least three weeks after treatment.

8. Call Indy Laser with any questions or concerns you may have after the treatment at (317)575-2737.

Please note: Stubbles, representing dead hair being shed from the hair follicle, will appear within 10-20 days from the treatment date. This is normal and will fall out quickly.

Initial_____