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 Consent Form for Laser Pigmentation Removal / Laser Skin Tightening / Laser Vein Removal

I, _____, authorize Indy Laser to perform laser skin tightening / laser pigmentation removal / laser vein removal treatments on me. I understand that the procedure is purely voluntary and multiple treatments may be necessary.

I understand that complications are rare, but possible. I have been informed that common side effects following the treatment include temporary redness, swelling, mild "sunburn" like effects, bumps, blistering, bruising, hypo pigmentation, and hyper pigmentation. Usually, if these occur, they are temporary and can resolve in a few days or weeks, in extremely rare cases, may last twelve months or longer. In addition, one may experience hair loss in the treated area, in rare cases, increase in growth. Other potential risks include, but are not limited to crusting, itching, and failure to achieve the desired result.

Eye damage may occur from the light and therefore, I agree to wear protective eyewear during all laser sessions.

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 or skin textural changes. 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 results might not be perfect and there may be more treatments necessary than anticipated. Clinical results vary per patient.

PHOTOGRAPHS: I give my permission for my photographs to be used to help document my treatment progress. Complete confidentiality will be maintained. (If you would not like your photograph to be taken, please notify the laser technician prior to treatment.)

I have read and understand all the information presented to me before signing this consent. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I release Indy Laser and its technicians from liability associated with the laser procedure.

Client Signature:_____ Date:_____
(Client or person legally authorized to consent for patient)

Witness Signature:_____ Date:_____

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)

INDYLASER™
Body | Hair | Skin

Indy Laser Hyperpigmentation
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)

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)

Signed: _________________________Date: _________ Current Phone: (___)__________Home/Cell/Work

(Patient or person legally authorized to consent for patient)

Indy Laser Hyperpigmentation Removal
Aftercare Instructions

Post Treatment Instructions:

1. Immediately after the treatments, you can apply a cold compress, as there may be mild swelling. It is normal for the treated area to feel like sunburn for a few hours. Avoid any trauma to the skin for up to 2-5 days, such as bathing with very hot water, strenuous exercise, or massage.

2. Avoid picking or scratching the treated skin to achieve your best results. 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. Follow instructions as specified by your laser professional.

3. Makeup may be used after the treatment has quit swelling unless there is epidermal bleeding. It is recommended to use new makeup to reduce the possibility of infection. Keep the area moist. Any moisturizer without alpha-hydroxy acids will work.

4. You may shower after the laser treatments in tepid water. The treated area may be washed gently with a mild soap. Skin should be patted dry and NOT rubbed.

5. You can experience redness and bruising from five to fourteen days at the treatment. Avoid direct sun exposure and tanning beds for 1-2 months and throughout the course of the treatment so as to reduce the chance of dark or light spots. Use sunscreen SPF 30 or higher at all times throughout the treatment when going outside.

6. Avoid tweezing, waxing, bleaching or chemical peels during the course of the treatment. Do not use any irritants such as Retin-A, Benzoyl Peroxide, alpha-hydroxy acids or astringents.

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

Initial_____