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_____

Informed Consent Venus Legacy

Patient Name _____

Treatment Sites _____

I hereby authorize a Treatment Professional and/or such assistants as may be selected to perform the following procedure and/or treatment:

_____

I understand that there is a possibility of short-term side effects from the Legacy treatment. I could experience edema (swelling), prolong redness in the area treated as well as slight heat discomfort/tingling. These side effects have been fully explained to me _____(patient initials) during my consultation/treatment.

I acknowledge that patient results may vary depending on many factors including, but limited to, medical history, and individual's response to treatment; patient compliance with pre and post treatment instructions or changes in medical condition prior to, during or after treatment has been completed.

I agree (if required/requested) to the photographing of appropriate portions of my body for medical, scientific or educational purposes, provided they do not reveal my identity.

I understand that the Legacy treatment protocol involves a series of treatments with a specific protocol involved along with a fee structure associated to this series. I agree to follow this treatment protocol and fee structure as it was explained to me _____(patient initials).

It has been explained to me by Indy Laser in a way that I understand:

i. The above treatment or procedure to be undertaken
ii. There are risks to the procedure/treatment proposed and I have been explained on what those risks are
iii. There is no guarantee on the final results that I will obtain
iv. The decision to proceed is based solely on my expressed desire to do so

_____

v. That I have informed the staff regarding any current or past medical condition, disease or medication that I am taking
vi. Any questions I may have asked have been answered to my satisfaction.

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS.

I AM SATISFIED WITH THE EXPLAINATIONS GIVEN.

_____

Client or Person Authorized to Sign For Client

Please Print Name Here

_____ _____

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)

Indy Laser Venus
Treatment Consent Form

I agree and confirm 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 professional skin care products or peels that contain acids such as lactic, glycolic, benzyl peroxide, salicylic, alpha-hydroxy, retin-a or prescription acne medications. I have not received any Botox, fillers or other injectables in the area being treated in the last 14(fourteen) days. 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

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