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 SPA SERVICES
CONSENT FORM

To the CLIENT: You have a right to be informed about your condition and its treatment, so that you make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give, or withhold, your consent for treatment.

1. I voluntarily request that Indy Laser (and such associates, technical assistants and other skincare professional she or he may deem necessary) to perform the Microdermabrasion or Chemical Peel procedure. I acknowledge having been informed that this cosmetic procedure is intended to remove surface layers of the skin to improve the vitality of the skin.

2. I understand that my skincare professional can discover other, or different conditions that may require additional or different procedures than those planned. If my skincare professional discovers such other or different conditions I will be referred to appropriate medical care provider.

3. I acknowledge that, while the goal of such a procedure is the removal of damaged skin, the realistic results average 50-75% improvement. I acknowledge that the practice of cosmetology is not an exact science and that no specific guarantees can or have been made concerning the expected result. Some clients are improved and in others no appreciable improvements is noticed.

4. I also realize that the following risks and hazards may occur in connection with the particular procedure; worsening or unsatisfactory appearance, creation of additional problems such as: poor healing or skin loss, nerve damage, painful unattractive scarring, or recurrence or the original condition.

5. I have been advised that I must use sunscreen of SPF 30 or greater at all times throughout the course of treatment.

6. I have been informed that there are risks such as loss of blood and infection that are attendant to the performance of any exfoliation procedure.

7. I have been advised of alternative methods available for my treatment, which includes acid peels and laser skin resurfacing.

8. I acknowledge my obligation to follow the written and spoken instructions covering my pre and post treatment skincare regimen.

9. I understand that multiple treatments may be required. The cost of these was disclosed prior to the first treatment.

10. I have received a thorough explanation of my pre-exfoliation and post-exfoliation instructions. I understand these instructions and have received copies for reference. I understand that should I have additional questions, I should not hesitate to call.

I certify that I have read the above consent and I fully understand it. I have been given ample opportunity for discussion and all my questions have been answered to my satisfaction. I hereby consent to the Microdermabrasion procedure. This constitutes the full disclosure and supersedes any previous verbal or written disclosures.

Client's Name (Please Print):_____

Client's Signature:_____

Date:_____ Time:_____

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 Spa Services
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 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)

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(Patient or person legally authorized to consent for patient)

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