



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
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 _____



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INDY LASER TATTOO INFORMATION FORM

Client Name: _____ Date: _____

Location of tattoo: _____

Age of tattoo: _____

Tattoo Performed by: _____

Did you have any scarring after getting the tattoo? _____

Did you have any adverse reactions from getting the tattoo? _____

Prior attempts of removing the tattoo: _____

Any other details you can provide: _____

For Office Use Only

Photo Taken _____

Tattoo Colors _____

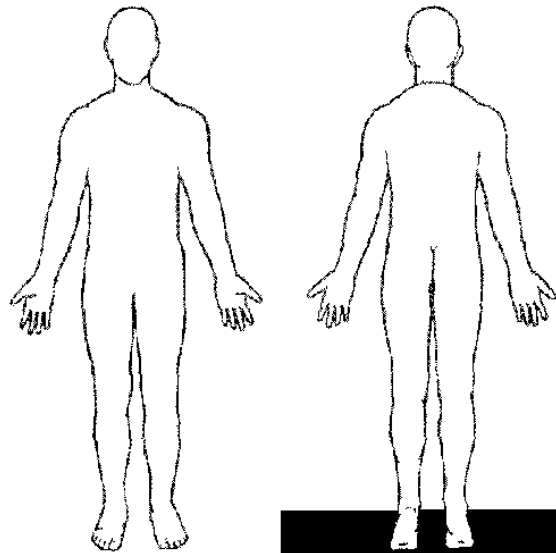
Reason Removing _____

Any Scarring _____

Referred By _____

Other Notes _____

Consult By _____



Front



Back

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 TATTOO REMOVAL

CONSENT FORM

I, _____ consent to and authorize Indy Laser and members of its staff to perform multiple treatments, laser procedures and related services on me. The procedure planned uses laser technology for the removal of tattoos.

The Hoya Conbio Medlite and Asclepion Ruby Star 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.

As a patient you have the right to be informed about your treatment so that you may make the decision whether to proceed for laser tattoo removal or decline after knowing the risks involved. This disclosure is to help to inform you prior to your consent for treatment about the risks, side effects and possible complications related to laser tattoo removal:

The following problems may occur with the tattoo removal system:

1. **The possible risks of the procedure include but are not limited to** pain, purpura, swelling, redness, bruising, blistering, crusting/scab formation, ingrown hairs, infection, and unforeseen complications which can last up to many months, years or permanently.
2. **There is a risk of scarring.**
3. **Short term effects may include reddening, mild burning, temporary bruising or blistering.** A brownish/red darkening of the skin (known as **hyperpigmentation**) or lightening of the skin (known as **hypopigmentation**) may occur. This usually resolves in weeks, but it can take up to 6-12 months or longer to heal. Permanent color change is a rare risk. Loss of freckles or pigmented lesions can occur.
4. **Textual and/or color changes in the skin can occur and can be permanent.** Many of the cosmetic tattoos and body tattoos are made with iron oxide pigments. Iron oxide can turn red-brown or black. Titanium oxide and other pigments may also turn black. This black or dark color may be unremovable. Because of the immediate whitening of the exposed treated area by the laser, there can be a temporary obscuring of ink, which can make it difficult or impossible to notice a specific color change from the tattoo removal process.
5. **Infection:** Although infection following treatment is unusual, bacterial, fungal and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a treatment. This applies to both individuals with a past history of herpes simplex virus infections and individuals with no known history of herpes simplex virus infections in the mouth area. Should any type of skin infection occur, additional treatments or medical antibiotics may be necessary.

6. **Bleeding:** Pinpoint bleeding is rare but can occur following treatment procedures. Should bleeding occur, additional treatment may be necessary.
7. **Allergic Reactions:** There have been reports of hypersensitivity to the various tattoo pigments during the tattoo removal process especially if the tattoo pigment contained Mercury, cobalt or chromium. Upon dissemination, the pigments can induce a severe allergic reaction that can occur with each successive treatment. Noted in some patients are superficial erosions, bruising, blistering, milia, redness and swelling which can last up to many months, years or permanently.
8. Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, and hyper-pigmentation. Aftercare guidelines include avoiding the sun for 2 months after the procedure. If it is necessary to be in the sun, a sunscreen with SPF 30 or greater must be used.
9. I understand that multiple treatments will be necessary to achieve desired results. No guarantee, warranty or assurance has been made to me as to the results that may be obtained. Complete tattoo removal is not always possible as tattoos were meant to be permanent.
10. In order to have a better view on the results of the procedure, and for educational and scientific purposes, such as presentations and scientific publications, photographs will be taken. The client will be turned unrecognizable on these pictures.

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 Tattoo Removal procedure.

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

Witness: _____

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 Tattoo 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)

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Indy Laser™ Tattoo Removal Aftercare Instructions

The tattoo removal laser treatment may create a superficial burn wound. Some clients may experience bruising or swelling. There is immediate whitening of the treated area, which usually lasts for several minutes. Many clients then develop blisters, crusts, or scabs within 12-72 hours, which may last for 1-2 weeks or more. The treated areas may be pink or pale after the scab separates. Loss of skin pigment in the treated area is common, and is usually temporary. Healing is usually complete by 4-8 weeks.

1. Keep the treated area clean and dry while it is healing. Clean the area gently with soap and water and then gently pat the area dry. You may apply a thin coating of antibiotic ointment up to three times a day while the area is healing if you keep the area covered with a sterile dressing.
2. You may apply cool compresses as necessary for 24 hours after the laser treatment to help reduce discomfort and inflammation. Avoid hot showers or hot tubs for 48hrs after treatment. You may take plain Ibuprofen, but avoid aspirin (it can increase the risk of bruising and/or bleeding.)
3. Do not pick at the scab or allow the skin to become scraped, as this may result in infection and scarring. Shaving should be avoided in the treated area until it is completely healed.
4. Do not wear makeup or any cream or medication unless recommended by our office for 48 hours.
5. Wear a sunscreen with an SPF of 30 or higher over the area for 3 months following the treatment.
6. If the area looks infected (honey colored crusting and oozing or spreading redness), if you experience an unusual discomfort or bleeding, if any other complications develop, or if you have any questions or concerns, contact the office immediately. Of course, if you have any extreme reaction (such as moderate to severe facial swelling, moderate to severe rash, any difficulty breathing, or you are in any distress) call 911 and go to the emergency department.

Initial _____