HYDRAFACIAL™ TREATMENT CONSENT FORM

Do you have any of the following?

- Active acne or infection ☐Yes ☐No
- Open lesion or cold sore ☐Yes ☐No
- An active infection in the treatment area ☐Yes ☐No
- Active sunburn ☐Yes ☐No
- Skin conditions such as eczema, dermatitis, or rashes ☐Yes ☐No
- An autoimmune disease such as lupus ☐Yes ☐No
- A viral concern such as HIV or hepatitis ☐Yes ☐No
- Anticoagulants Therapy ☐Yes ☐No
- Melanoma or lesions suspected of malignancy ☐Yes ☐No
- Pregnancy or lactation ☐Yes ☐No
- Neurological disorders such as epilepsy (LED Lights) ☐Yes ☐No
- Infection in the urinary system i.e. kidneys, bladder and urethra (Lymphatic drainage) ☐Yes ☐No
- Crohn's Disease (Lymphatic drainage) ☐Yes ☐No
- Hyperthyroidism (Lymphatic drainage) ☐Yes ☐No
- Deep Venous Thrombosis (Lymphatic drainage) ☐Yes ☐No
- Lymphedema (Lymphatic drainage) ☐Yes ☐No

Have you recently?

- Used Accutane, topical medications or antibiotics ☐Yes ☐No
- Had aesthetic fillers, injectables or laser treatments ☐Yes ☐No

I acknowledge the following:

- I will avoid the use of aggressive exfoliation, waxing, and products containing glycolic acids or retinols that are not part of the recommended take-home regimen in the treated areas for minimum 2 weeks pre-and post-treatment.
- The information provided has been explained to me and all my questions have been answered to my satisfaction. I have read the above information, and I give my consent to have the HydraFacial treatment by the staff at Lake Medical Spa.
- By signing below, I acknowledge that I have read the above information and give my consent to be treated with the HydraFacial System.
- This consent form is valid for all future HydraFacial treatments. I will alert the staff If there are any future changes to my medical history.

- Print name: _____ Signature: _____ Date: