Consent Form

Hyaluron Pen Pre and Post Procedure Instructions

How Does the Hyaluron Pen Work?

The hyaluron pen uses technology borrowed from the field of medicine to help you achieve a more youthful volume on the lips and other areas of the face. Using intense pressure, the pen device injects microparticles of hyaluronic acid deep into the skin without the use of a needle

How Long Does It Last?

This treatment lasts anywhere from 4-12 weeks. The duration of the effect is dependent upon the area treated and if this is an initial treatment. For lip augmentation with the hyaluron pen, having more than one treatment will greatly extend the length of time the results lasts from 6 months to a year. We cannot guarantee a specific length of time for how long the hyaluron pen effects last due to individual metabolism and lifestyle factors.

How Many Treatments Are Required?

One or two treatments may be needed to reach the desired volume effect. Since there is minimal swelling, the results you see will be close to your final result in 3-7 days. It is best to wait 2 weeks before receiving another treatment.

Precare

If you are receiving this treatment on the lips you can prepare for the treatment by using a mixture of sugar and coconut oil to exfoliate the lips one week before the session. Do not use vitamin E oil as this will promote bleeding. Drink plenty of water before your treatment for the best results. Hyaluronic acid can hold 1,000 times its weight in moisture. Anti-inflammatory supplements and medications such as aspirin, Vitamin E, ibuprofen and others should be discontinued a week prior to treatment.

Day of Treatment

Do not wear any makeup on the area to be treated. Avoid coffee or other caffeinated beverages before treatment. Your hyaluron pen session will take approximately 30 minutes. No numbing solution is needed for this procedure.

Post Treatment

You may notice some lumps, but these will subside on their own within a week. You can lightly massage the area to help the serum spread and even out. Do not exercise for 24 hours following treatment or engage in any swimming or sauna activities. Be sure to drink plenty of water to help improve the hyaluronic acid’s ability to volumize your treated area since it is a hydrophilic molecule that attracts moisture. Use petroleum jelly to keep the lips moisturized following treatment and wear an SPF lip balm if you will be outdoors. If you experience bruising, arnica cream can be rubbed on the area.

I, _____, have read and understand the above information and of my own free will I choose to move forward with my procedure. I acknowledge that not following pre and post treatment instructions may affect my results.

Signature: _____Date: _____

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Hyaluron Pen Release Form / Liability Waiver

I hereby consent to and authorize _____ to perform the following treatment:

_____

I recognize that individual results may vary and not all potential complications can be delineated. I fully accept the risks inherent in this procedure and have been informed of potential complications that can occur with this treatment. I understand that more than one treatment may be necessary to achieve my desired results at an additional cost.
I have read and fully understand the post care guidelines. I understand that if instructions are not followed I increase the risk of an undesirable outcome in this treatment. In the event that I may have questions or concerns regarding my treatment or post care instructions, I will contact the practitioner immediately.

I have also, to the best of my knowledge, provided accurate information concerning my medical history, including all known allergies, prescription drugs, supplements and any other products I am currently consuming.

I have read and fully understand this agreement and all information detailed above. I understand the treatment and accept the risks. All my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold the technician (nor the establishment), whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today. I also release _____ of any liability that may arise from this procedure.

Client Name (Printed)

_____

Client Name (Signature)

_____Date_____

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Date: _____ Name: _____ Date of Birth: _____ Address: _____ City: _____ State: _____ Age: _____ Phone #: (_____) _____ Email: _____

Known allergies and reactions:

_____

List current medications (topical & oral):

_____

Please check any of the following that apply:

Cancer		Eczema	
Diabetes		Immune Disorder	
Hysterectomy		Skin Disease/Disorder	
AIDS/HIV		Varicose	
Psoriasis		Veins/Phlebitis	
Spinal Injury		Pacemaker/Defibrillator	
Keloid Scarring		Thyroid Disorder	
Menopause		Blush/Redden Easily	
High/ Low Blood Pressure		Depression/Anxiety	
Claustrophobia		Bruise Easily	
Hormone Imbalance		Lupus	
Hepatitis A/B/C		Fibromyalgia	
Rosacea		Circulation Disorder	
Cold Sores		Metal Implants/ Pins	
Blood Clot Disorder		Heart Disease	

Other: _____

1. Do you smoke? Y / N
2. Are you pregnant? Y / N
3. Do you form keloid scars? Y / N
4. Have you received any type of lip injections within the past 3 months? Y / N
5. Have you ever received lip injections in the past at any time? Y / N
6. Do you follow a special diet? Y / N
7. What is your daily intake of Water? _____oz. Caffeine? _____oz. Alcohol? _____oz.
8. Are you currently under the care of a physician or dermatologist for any medical condition? Y / N

If so, explain.

_____

9. Any surgeries within the last 6 months? Y / N If so, explain.

_____

10. Have you received dermal injections, fillers or Botox within the last 6 months? Y / N If so, explain.

_____

11. Are you currently using any products that contain Retin-A, Renova, Adapalene, Alpha Hydroxy Acids, Tretinoin, Differin, Glycolic Acid, Salicylic Acid, Lactic Acid, Retinol, Vitamin A, Accutane or any other prescription or over the counter skin product? Y / N
12. Have you used any of these products in the past 3 months? Y / N If so, explain.

_____

13. Have you ever had any allergic reaction to any skincare products? Y / N If so, explain:

_____

Client Consultation:

I understand, have read and completed the questionnaire with accuracy. I agree that this form is a full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications, side effects and an undesirable outcome from the treatment received. I am aware that it is my responsibility to inform the practitioner of my current medical or health conditions and to update this history. I understand that the services offered are not a substitute for medical care and any information provided by the practitioner is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the practitioner in giving better service and is completely confidential. The treatments I receive here are voluntary and I release _____ and_____ from any liability and assume full responsibility thereof.

Patient Signature _____Date: _____

Practitioner Signature _____Date: _____

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Email Address: _____

Photographic Consent: I consent to photographs being taken before, during and after each procedure. I agree to these photos being stored electronically in my case file and will be used only with my written consent for promotional purposes.

Patient Signature: _____Date: _____

Patch Test Waiver:

(A) I understand that a skin test can determine whether or not I will experience a reaction to the products used within 48 hours prior to the treatment. However, I accept this will be inconclusive as to whether I have an allergic reaction at any time in the future. I therefore waive my option to an allergy test and wish to proceed with treatment. _____ (B) I have undergone or been ordered an allergy test prior to my initial treatment. I therefore release (practitioner name/company) _____ from liability related to any allergic reaction I may experience associated with either the application of the pretreatment cream or any other products used before, during and after my procedure, immediately or at a later date. _____

Patient Signature: _____ Date: _____

In case the case of an emergency , please contact:

Name: _____ Number: _____

Relation: _____