Laser Essential

OFFICE: 240-542-4316
CELL: 202-600-1606

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9658 BALTIMORE AVE, SUITE 101, COLLEGE PARK, MD 20740

TREATMENT SHEET

PATIENT NAME: _____ DATE: _____

EQUIPMENT 1: _____ HANDPIECE: AREA(S): _____

EQUIPMENT 2: _____ HANDPIECE: AREA(S): _____

REASON FOR VISIT: ☐ SUN DAMAGE ☐ MELASMA ☐ SKIN REJUVENATION ☐ SKIN TIGHTENING ☐ HAIR REMOVAL ☐ SKIN TAGS ☐ WRINKLE REDUCTION ☐ ACNE ☐ ACNE SCARING ☐ CELLULITE REDUCTION ☐ CHEMICAL PEEL ☐ MICRODERMABRASION ☐ TATTOO REMOVAL ☐ VEIN REDUCTION ☐ TEETH WHITENING ☐ OTHER: _____

SUN EXPOSURE: YES_____ NO_____ INITIALS:_____ MEDICAL/MEDICATION CHANGES: YES _____ NO _____ INITIALS:_____

RECENT INJECTION? ☐ BOTOX ☐ FILLERS ☐ NONE WHEN: _____ INITIALS: _____

TEST SPOT:

AREAS:_____

SETTING:_____

RESPONSE:_____

TECH INITIALS:_____

AREA TREATED: FACE (CHECK AREAS THAT APPLY WITH CORRESPONDING SETTINGS USED)

FULL FACE:_____ CHIN :_____

_____ UPPER LIP:_____

_____ BEARD :_____

_____ NECK :_____

_____ OTHER :_____

AREA TREATED:

AXILLE:_____ SHOULDERS:_____ BREASTS:_____

FULL BACK: _____ LOWER BACK: _____ AREOLA: _____

BIKINI LINE:_____ BIKINI:_____ BRAZILIAN:_____

CHEST:_____ HANDS:_____ BUTTOCKS:_____

ABS:_____ FEET/TOES:_____ LOWER LEGS:_____

LOWER ARMS:_____ UPPER ARMS:_____ UPPER LEGS:_____

CLINICAL ENDPOINT: EDEMA (MILD/MEDIUM) ERYTHEMA (MILD/MEDIUM) PATIENT TOLERANCE: GOOD FAIR POOR

PFE: YES/NO SPF: YES/NO HYDROCORTISONE: YES/NO POST ICE: YES/NO POST CARE REVIEWED: YES/NO

NOTES: _____

_____

_____

PATIENT PRIINT NAME:	PATIENT SIGN NAME PLEASE:

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CANCELLATION POLICY

APPOINTMENTS

LASER ESSENTIAL REQUIRES A 48 HOUR NOTICE TO CANCEL OR RESCHEDULE AN APPOINTMENT.
IN THE EVENT THAT YOU MISS A SCHEDULED APPOINTMENT, OR DO NOT CANCEL YOUR APPOINTMENT 48 HOURS PRIOR, YOUR CARD ON FILE OR YOUR ACCOUNT WILL BE CHARGED A $50.00 NO SHOW FEE. $75.00

$100 IF YOU ARRIVE MORE THAN FIFTEEN MINUTES LATE FOR YOUR APPOINTMENT, WITHOUT CALLING TO INFORM STAFF OF YOUR INTENTIONS AND CIRCUMSTANCES, IT WILL BE CONSIDERED A "NO SHOW" AND AT THAT TIME, LASER ESSENTIAL MAY CHARGE A $50.00 NO SHOW FEE.

BECAUSE OF THE FREQUENCY OF OCCURRENCES, THIS POLICY WILL BE STRICTLY ENFORCED

I AGREE AND UNDERSTAND LASER ESSENTIALS CANCELLATION POLICY.

PRINT NAME:_____

CLIENT SIGNATURE:_____

DATE:_____

WITNESS:_____

DATE:_____

NO REFUND:

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NEW CLIENT HISTORY

FIRST NAME:_____DATE:_____

LAST NAME:_____BIRTH DATE:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP CODE:_____

CELL PHONE:_____HOME PHONE:_____WORK PHONE:_____

EMAIL (OPTIONAL):_____OCCUPATION:._____

HOW DID YOU HEAR ABOUT US?_____

WHAT BRINGS YOU TO LASER ESSENTIAL_____

ETHNIC BACKGROUND:_____

MEDICAL HISTORY

DO YOU HAVE ANY CHRONIC MEDICAL CONDITIONS WHICH WE SHOULD KNOW ABOUT? YES NO

IF SO, PLEASE LIST:_____

DO YOU HAVE ANY ALLERGIES TO LATEX, MEDICATIONS, HERBAL OR NATURAL SUPPLEMENTS? YES NO

IF SO, PLEASE LIST:_____

DO YOU HAVE, OR HAVE YOU HAD, ANY CHANGES IN MEDICAL HISTORY RECENTLY? YES NO

PLEASE LIST ANY AND ALL CURRENT/PAST SURGERIES OR SURGICAL PROCEDURES._____

_____

HAVE YOU TAKEN ACCUTANE WITHIN THE PAST YEAR? YES NO

ARE YOU ON ANY ANTICOAGULANTS, DAILY ASPIRIN, MOTRIN, OR ADVIL? YES NO

ARE YOU A SMOKER? YES NO

DO YOU HAVE VENEERS ON YOUR TEETH? YES NO

DO YOU HAVE A HISTORY OF COLD SORES, FEVER BLISTERS OR HERPES 1 OR 2?

IF SO, WHEN WAS YOUR LAST OUTBREAK? _____*THE USE OF LASERS AND IPL CAN TRIGGER AN OUTBREAK

DO YOU HAVE A HISTORY OF HYPO/ HYPER-PIGMENTATION? YES NO

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WHAT SKIN CARE PRODUCTS ARE YOU CURRENTLY USING?_____

ARE YOU HAPPY WITH YOUR SKIN CARE PRODUCTS? YES NO

DO YOU OR HAVE YOU USED ANY TOPICAL MEDICATIONS OR CREAMS SUCH AS
RETIN-A, RENOVA, TAZORAC, DIFFERIN, OBAGI, OR ANY OTHERS? YES NO

IF SO, PLEASE LIST:_____

DO YOU HAVE PERMANENT MAKEUP OR TATTOOS? YES NO

IF SO, PLEASE LIST;_____WHEN WAS LAST USE?_____

WOMEN ONLY:

ARE YOU OR COULD YOU BE PREGNANT? YES NO

ARE YOU CURRENTLY BREAST-FEEDING? YES NO

ARE YOU MENSTRUAL CYCLES NORMAL? YES NO

PLEASE TELL US ABOUT YOUR SKIN (CHECK ALL THAT APPLY):

- ☐ NORMAL
- ☐ DRY
- ☐ OILY
- ☐ ACNE
- ☐ LARGE PORES
- ☐ MELASMA
- ☐ HYPER-PIGMENTATION
- ☐ HYPO-PIGMENTATION
- ☐ BROKEN CAPILLARIES

NATURAL HAIR COLOR:_____EYE COLOR:_____

HAVE YOU HAD ANY RECENT SUN EXPOSURE IN THE PAST 4-6 WEEKS,
INCLUDING TANNING BEDS, BRONZING CREAMS OR SPRAY-ON TANS? YES NO

IF SO, PLEASE SPECIFY:_____

WHAT ARE YOUR SKINCARE GOALS?_____

ADDITIONAL INFORMATION YOU WOULD LIKE YOUR TECHNICIAN TO KNOW:_____

_____

_____

CLIENT SIGNATURE:_____DATE:_____

WITNESS:_____DATE:_____

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DEPOSIT / PAYMENT INFORMATION

CREDIT CARD AUTHORIZATION

CREDIT CARD TYPE: ☐ VISA ☐ MASTER CARD ☐ AMERICAN EXPRESS ☐ DISCOVER ☐

CARDHOLDERS NAME_____

ADDRESS_____

CITY. STATE & ZIP_____

CREDIT CARD NUMBER_____

EXPERIAN DATE_____

SECURITY CODE_____

AUTHORIZED AMOUNT US$_____

_____

NAME ON CREDIT CARD AUTHORIZED SIGNATURE

NO REFUND:

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CLIENT RIGHTS AND RESPONSIBILITIES

WE ARE COMMITTED TO SERVING YOU WITH COMPASSION, CARE, AND RESPECT. AS ONE OF OUR VALUED CLIENTS YOU ARE ENTITLED TO THE FOLLOWING:

YOU HAVE THE RIGHT:

TO BE TREATED WITH RESPECT AND DIGNITY.
TO KNOW THE NAMES AND PROFESSIONAL STATUS OF THE PERSON(S) SERVING YOU.
TO PRIVACY AND CONFIDENTIALITY.
TO RECEIVE ACCURATE INFORMATION ABOUT YOUR HEALTH-RELATED CONCERNS.
TO KNOW THE EFFECTIVENESS AND POTENTIAL SIDE-EFFECTS OF ALL FORMS OF TREATMENT.
TO REVIEW YOUR MEDICAL RECORD WITH YOUR CHILDREN.
TO RECEIVE ANY INFORMATION ABOUT POTENTIAL SERVICES OR RELATED SERVICES.

YOU HAVE THE RESPONSIBILITY:

TO SEEK MEDICAL ATTENTION PROMPTLY, AND TO PROVIDE USEFUL FEEDBACK.
TO BE HONEST ABOUT YOUR MEDICAL HISTORY.
TO BE HONEST ABOUT YOUR SUN EXPOSURE.
TO ASK QUESTIONS ABOUT ANYTHING YOU DO NOT UNDERSTAND.
TO FOLLOW HEALTH ADVICE AND INSTRUCTIONS.
TO REPORT ANY SIGNIFICANT CHANGES IN YOUR HEALTH.
TO RESPECT CLINIC POLICIES.
TO SHOW UP TO APPOINTMENTS OR CANCEL 48 HOURS IN ADVANCE.

I AUTHORIZE LASER ESSENTIAL TO PERFORM THE TREATMENT OR PROCEDURES RECOMMENDED. I ACKN EDGE NO GUARANTEE; EITHER EXPRESSED OR IMPLIED HAS BEEN MADE TO ME REGARDING THE OUTCOI ANY TREATMENT OR PROCESS.

I FULLY UNDERSTAND THAT IT IS IMPOSSIBLE FOR ANYONE TO MAKE A GUARANTEE REGARDING THE OUTCOME OF ANY MEDICAL TREATMENTS OR PROCEDURES. **NO REFUNDS OR SWITCHING OF TREATMENT ONCE TREATMENT BEGINS.**

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL PROCEDURES DUE WHEN SERVICES ARE RENDERED, AND FOR ANY APPOINTMENT I FAIL TO ATTEND WITHOUT 48 HOURS NOTICE.
I AUTHORIZE THE RELEASE OF INFORMATION TO A LICENSED PHYSICIAN OF THE FACILITY'S CHOOSING FOR THE PURPOSE OF PROFESSIONAL INTERPRETATION AND ESTABLISHMENT OF THEIR RECOMMENDATIONS.

CLIENT SIGNATURE:_____DATE:_____

REVIEWED BY:_____DATE:_____

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POST CARE FOR EMATRIX

IMMEDIATELY AFTER THE TREATMENT YOUR SKIN SHOULD FEEL LIKE A DEEP SUNBURN. YOU SHOULD EXPECT ERYTHEMA AND EDEMA TO THE TREATED AREA. THIS WILL SUBSIDE WITHIN A DAY OR TWO.

POST-TREATMENT COOLING IS NOT NECESSARY, BUT IN THE EVENT OF DISCOMFORT YOU MAY APPLY COLD ICEPACK OR COOL AIR.

TINY PIN POINT SCABS WILL APPEAR 24-72 HOURS POST-TREATMENT AND MAY REMAIN FOR 3-7 DAYS FOLLOWING. THE SCABS SHOULD NOT BE TOUCHED, ITCHED OR EXFOLIATED THEY WILL NATURALLY SHED OFF WHEN READY.

DURING THE NEXT 48 HOURS POST-TREATMENT YOU SHOULD AVOID WORKING OUT, HOT SHOWERS, MASSAGES, SUN EXPOSURE, ETC. THE SKIN SHOULD BE KEPT CLEAN TO AVOID CONTAMINATION OR INFECTION WHILE IT IS HEALING.

WOMEN - DO NOT APPLY ANY MAKEUP TO YOUR SKIN FOR 12 HOURS AFTER TREATMENT WHILE YOUR SKIN IS HEALING. YOU MAY START APPLYING EMOLLIENT CREAMS TO ALLEVIATE ANY DRY, TIGHT OR ITCHY SENSATIONS WHILE YOUR SKIN IS HEALING.

MEN - DO NOT SHAVE FOR 1-2 DAYS POST-TREATMENT WHILE YOUR SKIN IS HEALING. YOU MAY START APPLYING EMOLLIENT CREAMS TO ALLEVIATE ANY DRY, TIGHT OR ITCHY SENSATIONS WHILE YOUR SKIN IS HEALING.

YOU SHOULD APPLY A HIGH-FACTOR SUNSCREEN (AT LEAST 30SPF) AND PROTECT THE TREATED AREA FROM SUNLIGHT FOR A MONTH. SUN EXPOSURE MAY CAUSE HYPERPIGMENTATION.

TREATMENTS VARY DEPENDING ON SKIN CONDITIONS BUT TYPICAL PROTOCOL IS BETWEEN 3-4 SESSIONS AND EVERY 4-6 WEEKS BETWEEN SESSIONS.

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CONSENT FOR PULSED LIGHT/LASER TREATMENT

I GIVE MY CONSENT AND AUTHORIZATION TO LASER ESSENTIALS TO TREAT ME WITH COSMETIC LASER AND/OR PULSED LIGHT INTENSE MODALITIES. THIS LIGHT HAIR INCLUDES, REMOVAL, BUT IS NOT LIMITED TO, PHOTO FACIALS, FRACTIONAL LASER SKIN RESURFACING, LASER AND INTENSE PULSE LIGHT HAIR REMOVAL, LIGHT-BASED TREATMENT OF PIGMENTED VASCULAR LESIONS, INTENSE PULSE LIGHT ACNE REDUCTION. SUBIATIVE SKIN REJUVENATION, GLYCOLIC OR UI PEEL TREATMENTS

I UNDERSTAND THAT THESE PROCEDURES ARE PURELY ELECTIVE, THAT THE RESULTS MAY VARY WITH EACH INDIVIDUAL, NO GUARANTEE CAN BE PROVIDED IN REGARDS TO THE OUTCOME OF MEDICAL PROCEDURES SUCH AS THESE, AND MULTIPLE TREATMENTS MAY BE NECESSARY TO ACHIEVE MAXIMUM RESULTS.

I ACKNOWLEDGE AND UNDERSTAND THAT:

SERIOUS COMPLICATIONS ARE RARE, BUT POSSIBLE.
COMMON SIDE EFFECTS INCLUDE TEMPORARY REDNESS AND MILD "SUNBURN" LIKE EFFECTS THAT MAY LAST ANYWHERE FROM A FEW HOURS TO 3-4 DAYS.

PIGMENT CHANGES, INCLUDING HYPO-PIGMENTATION (LIGHTENING OF SKIN) OR HYPER-PIGMENTATION (DARKENING OF SKIN) LASTING 1-6 MONTHS OR LONGER, MAY OCCUR.

FRECKLES MAY TEMPORARILY OR PERMANENTLY DISAPPEAR IN TREATED AREAS.

OTHER POTENTIAL RISKS INCLUDE CRUSTING, ITCHING, PAIN, BRUISING, BURNS, INFECTION, SCABBING, SCARRING, SWELLING, AND FAILURE TO ACHIEVE THE DESIRED RESULT.

LASER AND INTENSE PULSE LIGHT TREATMENTS CAN CAUSE EYE INJURY AND PROTECTIVE EYEWEAR MUST BE WORN DURING ALL TREATMENTS.

I UNDERSTAND THAT SUN OR TANNING LAMP EXPOSURE AND NOT ADHERING TO THE POST-CARE INSTRUCTIONS PROVIDED BY LASER ESSENTIAL MAY INCREASE MY CHANCES OF COMPLICATIONS.

I CONSENT TO PHOTOGRAPHS BEING TAKEN FOR USE IN THE FOLLOW AREAS: EVALUATIONS OF TREATMENT EFFECTIVENESS, MEDICAL EDUCATION AND TRAINING, MARKETING, MEDIA STORIES, ADVERTISING AND OTHER SALES PURPOSES. NO PHOTOGRAPHS REVEALING MY IDENTITY WILL BE USED WITHOUT MY WRITTEN CONSENT. IF MY IDENTITY IS NOT REVEALED, THESE PHOTOGRAPHS MAY BE USED AND DISPLAYED PUBLICALLY WITHOUT MY PERMISSION.

CONSENT ( ) DO NOT CONSENT ( )

CLIENT SIGNATURE: _____ DATE: _____

PRINT NAME: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

PRINT NAME: _____ DATE: _____

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PRE AND POST CARE FOR LASER HAIR REDUCTION AND PHOTOFACIALS

PRE:

AVOID THE SUN FOR 4-6 WEEKS BEFORE AND AFTER THE TREATMENT.

AVOID ELECTROLYSIS, PLUCKING, AND/OR WAXING FOR 6 WEEKS PRIOR TO TREATMENT.

IF YOU HAVE A HISTORY OF HERPES, PROPHYLACTIC ANTIVIRAL THERAPY MUST BE STARTED THE DAY BEFORE TREATMENT AND CONTINUED ONE WEEK AFTER TREATMENT.

THE USE OF TANNING CREAMS, TANNING BEDS, OR BRONZERS MUST BE DISCONTINUED BEFORE AND DURING TREATMENTS.

POST:

IMMEDIATELY AFTER TREATMENT THERE MAY BE ERYTHEMA (REDNESS) AND EDEMA (SWELLING) AT THE TREATMENT SITE. THIS USUALLY LASTS 2 HOURS OR LONGER. THE ERYTHEMA MAY LAST UP TO 10 DAYS. THE TREATMENT AREA MAY FEEL LIKE A SUNBURN FOR A FEW HOURS AFTER THE TREATMENT, BUT IT WILL SUBSIDE.

APPLY ICE AS NEEDED.

HYDROCORTISONE MAY BE USED FOR 3 -- 5 DAYS POST TREATMENT.

NO HEAT, SUCH AS SAUNAS, STEAM ROOMS, JACUZZIS, EXTREMELY HOT SHOWERS, OR STRENUOUS ACTIVITIES, NO PROLONGED HEAT FOR A MINIMUM OF 48 HOURS POST TREATMENT.

AVOID SUN EXPOSURE TO AVOID HYPO-PIGMENTATION AND HYPER-PIGMENTATION.

AVOID PICKING OR SCRATCHING THE TREATED AREAS. PLEASE DO NOT USE ANY HAIR REMOVAL PRODUCTS OR SIMILAR TREATMENTS (I.E. ELECTROLYSIS, PLUCKING, AND/OR WAXING). THOSE WILL DISTURB THE HAIR FOLLICLE. SHAVING IS PERMITTED.

UP TO 2 WEEKS POST TREATMENT YOU WILL NOTICE SHEDDING OF THE TREATED HAIR. THIS IS NOT NEW GROWTH. YOU CAN CLEAN AND REMOVE THE HAIR BY WASHING OR WIPING THE AREA WITH A WET CLOTH.

TREAT YOUR SKIN GENTLY FOR AT LEAST 24 HOURS AFTER YOUR TREATMENT.

I HAVE READ AND UNDERSTAND THE PRE AND POST TREATMENT INSTRUCTIONS.

CLIENT SIGNATURE: _____ DATE: _____

PRINT NAME: _____ DATE: _____

PROVIDER SIGNATURE: _____ DATE: _____

PRINT NAME: _____ DATE: _____

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LASER SCREENING

NAME:_____DATE:_____

IF YOU ANSWER YES TO ANY OF THESE QUESTIONS YOU MAY NOT BE ABLE TO PARTICIPATE IN CERTAIN LASER TREATMENTS AT THIS TIME

ARE YOU PREGNANT? YES NO

DO YOU OR HAVE YOU HAD SKIN CANCER? YES NO

IF SO, WHERE DID YOU HAVE SKIN CANCER? AREA(S)_____

IS IT IN THE AREA YOU ARE WANTING TO TREAT WITH FRACTIONAL? YES NO

WHEN WAS YOUR LAST DERMATOLOGIST CHECK? DATE:_____

DO YOU EXPERIENCE KELOID SCARRING OR ANY OTHER TEXTUAL SKIN CHANGES AFTER PROCEDURES? YES NO

ARE YOU CURRENTLY ON ANY TOPICAL OR ORAL ANTIBIOTIC ACNE MEDICATION? YES NO

IF SO, WHAT ARE YOU USING? MEDICATION(S):_____

WHEN WAS YOUR LAST DOSE? DATE(S):_____

HAVE YOU RECENTLY BEEN ON ACCUTANE? YES NO

WHAT IS YOUR ETHNIC BACKGROUND (I.E. ITALIAN, FRENCH, HISPANIC, AFRICAN AMERICAN, ETC.)?

THE FOLLOWING ARE PRECAUTIONARY WHEN PARTICIPATING IN CERTAIN LASER TREATMENTS.

DO YOU USE EXFOLIATING PRODUCTS? (I.E. RETIN-A, RETINOL, OR AGGRESSIVE SCRUBS) YES NO

IF SO, WHEN WERE THEY LAST USED?_____

DO YOU HAVE A COLD, THE FLU, OR ANY OTHER SICKNESS? YES NO

DO YOU TAKE CORTICO STEROIDS? YES NO

DO YOU HAVE BLOOD DISORDERS? YES NO

DO YOU USE BLOOD ANTICOAGULANTS? YES NO

DO YOU HAVE HERPES IN OR AROUND THE TREATMENT AREA? YES NO

IF SO, YOU MUST TAKE AN ANTIVIRAL FOR 2 DAYS PRIOR TO TREATMENT, DAY OF TREATMENT, AND 2 DAYS POST TREATMENT.

DO YOU HAVE DIABETES OR ANY OTHER MEDICAL CONDITION THAT WILL IMPAIR THE HEALING PROCESS? YES NO

DO YOU EXPERIENCE VITILIGO? YES NO

DO YOU HAVE ECZEMA OR PSORIASIS? YES NO

DO YOU EXPERIENCE ALLERGIC DERMATITIS? YES NO

IS YOUR IMMUNE SYSTEM COMPROMISED IN ANY WAY? (I.E. HIV, STEROIDS OR AGE) YES NO

DO YOU HAVE ANY COLLAGEN DISEASES SUCH AS EHLERS-DANLOS OR SCLERODERMA? YES NO

DO YOU HAVE ANY SOCIAL ENGAGEMENTS IN THE NEXT 2 DAYS? YES NO

DO YOU CURRENTLY HAVE ANY DERMAL FILLERS IN THE TREATMENT AREA? YES NO