



Name _____

Date _____

Thank you for choosing Enhance Medical Aesthetics. In our ongoing efforts to provide you with the best possible service, we ask that you carefully review this consent form and ask any questions necessary to help you fully understand it. Please sign only after careful review and consideration.

Disclosure of Medical History

I agree that I will disclose a full and accurate personal medical history, including any and all information regarding medical conditions and my use of medications, drugs, herbs, vitamins, or other supplements of any kind. I understand that failure to do so may affect my treatment outcome and increase the likelihood or severity of complications.

Confidentiality

I understand that no information regarding services performed shall be released without my express consent.

Photo Consent

I understand that photographs may be taken to document treatment results, but they will not be released or used otherwise without my specific written consent.

Skin Care Products

I understand that some of the skin care products offered by Enhance Medical Aesthetics are professional strength and formulated to aggressively treat problem skin. I agree that I will use any skin care products obtained from Enhance Medical Aesthetics in accordance with the instructions and directions provided to me and only after becoming acquainted with the product and its recommended use. I realize that I may experience varying degrees of discomfort, redness, burning, peeling, itching, dryness or other skin symptoms, especially in the early stages of use. These symptoms should lessen and eventually subside as my skin tolerance develops. I understand that in unusual circumstances, use of these professional strength products could be harmful and even cause injury to the skin (infection, discoloration, superficial scarring, etc.). I will discontinue use and notify Enhance Medical Aesthetics if any unusual or concerning irritation occurs. I will not use any of these professional strength products if I am nursing, pregnant or trying to become pregnant. I understand that long term use is necessary to achieve and retain the desired benefits.

Testimonials

Would you agree to have clients contact you to discuss your experience at Enhance Medical Aesthetics?

Yes No

If so, preferred method of contact _____ Phone _____ E-mail

Cancellation Policy

_____ I agree to contact Enhance Medical Aesthetics at least 48 hours in advance if I need to cancel or reschedule my appointment. I understand that I may be required to pay a \$50.00 (fifty dollars) missed appointment fee.

_____ I understand that if I arrive more than 15 minutes late for my appointment I may be required to reschedule in order to avoid disrupting the appointments of other patients.

Treatment Consent Form

As an Enhance Medical Aesthetics patient, you will be provided with the opportunity to review your treatment with the medical professional(s) responsible for your care before receiving treatment of any kind. You will be advised of the manner in which treatment will be provided, the risks involved and any alternative that is available for your consideration and will be given the opportunity to ask questions. By executing this form, you agree that the Enhance Medical Aesthetics staff has reviewed with you and answered your questions.

- _____ I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied.
- _____ I understand that to achieve maximum and continued results the protocol recommended by Enhance Medical Aesthetics must be followed.
- _____ I understand that there are no guarantees implied as to the results of this treatment, due to many variables, such as: age, skin type, skin condition, sun damage, smoking, alcohol, environmental exposures, etc. I understand that I may or may not actually see demonstrable visual results, that each case is individual. I understand that the number of treatments may vary and that results may vary by the individual.
- _____ I acknowledge that I have been candid in revealing any condition which might have an effect on this treatment, such as: pregnancy, medications, previous or recent skin surgery or treatment, skin cancer, cold sores/ fever blisters, allergies, use of Retin-A, Accutane, Differin or hormones.
- _____ I understand that direct sun exposure is prohibited while I am undergoing some treatments. The use of sunblock protection with a minimum SPF of 30 is recommended. I agree to refrain from skin tanning in tanning booths while I am undergoing treatment, and during the 14 days following my last treatment.
- _____ If I am prone to Herpetic outbreaks around the mouth, I have been advised to see my physician for a prescription for acyclovir or zovirax.
- _____ I agree to refrain from any cosmetic skin care treatment for 14 days preceding and 14 days following any treatment with Enhance Medical Aesthetics, including filler injections and Botox.
- _____ I understand that I will not be allowed to have treatments during pregnancy. My unused treatment fees will be refunded or the unused portion will be placed on hold.

The following points have been discussed with me:

- The potential benefits of the proposed procedure.
- The possible alternative procedures.
- The probability of success.
- The most likely possible complications/risks involved with the proposed procedure and subsequent healing period, including, but not limited to, infection, scarring, crusting, re-growth of hair, and/or blistering.
- Post treatment instructions

I am aware of the following possible experiences/risks with Laser Surgery:

- DISCOMFORT – Some discomfort may be experienced during laser treatment.
- WOUND HEALING – Laser Surgery can result in swelling, blistering, crusting, or flaking of the treated areas, which may require one to three weeks to heal. Once the surface has healed, it may be pink or sensitive to the sun for an additional two to four weeks, or longer in some patients.

Name _____

- BRUISING/SWELLING/INFECTION – With some lasers, bruising of the treated area may occur. Additionally there may be some swelling noted. Finally, skin infection is a possibility although rare, whenever a skin procedure is performed.
- PIGMENT CHANGES (Skin Color) – During the healing process, there is a slight possibility that the treated area can become either lighter or darker in color compared to the surrounding skin. This is usually temporary, but on a rare occasion, it may be permanent.
- SCARRING – Scarring is a rare occurrence, but it is a possibility when the skin’s surface is disrupted. To minimize the changes of scarring, it is IMPORTANT that you follow all post treatment instructions carefully.
- EYE EXPOSURE – Protective eyewear (shields) will be provided. It is important to keep these shields on at all times during the treatment in order to protect your eyes from accidental laser exposure.

I have read and understand this agreement and all my questions have been addressed and answered to my satisfaction. I consent to the terms of this agreement.

Signature: _____

Witness: _____

Date: _____

Consent for Microdermabrasion/Chemical Peel

_____ I understand that microdermabrasion/peel is an exfoliating treatment intended to remove the surface dead cells and debris from skin and promote renewal. I understand that this treatment cannot be done in the presence of open lesions, active cold sores, acute dermatitis or irritation.

_____ I understand that I need to report prior skin treatments such as phenol or deep peel within the past year or a course of Accutane within the past 6 months prior to receiving microdermabrasion as these may make my skin more susceptible to damage.

_____ I understand that there are potential risks and complications that may require further treatment. These include but are not limited to: discomfort, changes in pigmentation, swelling of the area treated, scarring, infections, blistering, bruising, itchiness and redness.

I have read and understand this agreement and all my questions have been addressed and answered to my satisfaction. I consent to the terms of this agreement.

Signature: _____

Witness: _____

Date: _____

Consent for Vein Treatment

_____ I hereby authorize and direct any associates or assistants of Dr. Morgenthaler to remove or lighten the appearance of dilated superficial veins on the legs. The procedure involves using a laser to coagulate the vessels and it is possible the result will be minimal or no help at all. It is not possible to make every vein disappear.

_____ I will not expose my veins to the sun for a minimum of one month.

Name _____

_____ I am aware that there may be temporary worsening of the appearance.

I have read and understand this agreement and all my questions have been addressed and answered to my satisfaction. I consent to the terms of this agreement.

Signature: _____

Witness: _____

Date: _____

Consent for the Titan Procedure

_____ I hereby authorize Dr. Morgenthaler and / or associates to treat me with the Titan device. I understand that this procedure works by creating a thermal response in the dermis that induces tightening of skin laxity and collagen enhancement without damage to the outer layer of skin. There is little or no downtime associated with this treatment. It is possible the result will be minimal or no help at all.

_____ As collagen degradation is a normal physiological event, I understand that permanent skin rejuvenation is not possible without continued treatments.

I have read and understand this agreement and all my questions have been addressed and answered to my satisfaction. I consent to the terms of this agreement.

Signature: _____

Witness: _____

Date: _____

Consent for Laser Genesis Procedure

_____ I hereby authorize Dr. Morgenthaler and / or associates to perform Laser Genesis Non-Ablative skin therapy on me. I understand that this procedure works on promoting vibrant and healthy looking skin. The Laser Genesis procedure is a revolutionary way to combat the signs of aging, without harsh chemicals or long recovery periods.

_____ As collagen degradation is a normal physiological event, I understand that permanent skin rejuvenation is not possible without continued treatments.

I have read and understand this agreement and all my questions have been addressed and answered to my satisfaction. I consent to the terms of this agreement.

Signature: _____

Witness: _____

Date: _____

Name _____

Consent for Pigmented Lesion Therapy

_____ I hereby authorize and direct any associates or assistants of Dr. Morgenthaler to perform pigmented lesion treatment on me. I understand that this procedure works on removing pigmented lesions, age and sun spots by targeting the areas to be treated with a bright pulsed light. I hereby confirm I had a discussion with my physician/nurse regarding pulsed light therapy and its benefits and consequences.

I have read and understand this agreement and all my questions have been addressed and answered to my satisfaction. I consent to the terms of this agreement.

Signature: _____

Witness: _____

Date: _____

Consent for Laser Hair Removal

_____ I understand that the laser is intended for hair removal and that clinical results may vary with different skin types, color and location.

_____ I understand that to achieve maximum results the protocol prescribed by Enhance Medical Aesthetics should be adhered to. The treatment schedule is designed to maximize the results during the treatment of each hair cycle. If for any reason the schedule cannot be adhered to, I understand that the total percentage of hair loss could be affected and additional treatments may be necessary.

_____ I understand I need to stop tweezing, waxing, bleaching, using depilatories or any substance that will damage the hair in the follicle. I understand I need to shave, trim, clip or cut any of the surface hair before I have a treatment. I understand that the skin may be more sensitive if shaved at the time of the treatment.

_____ I understand excessive sun exposure must be avoided for a minimum of two weeks prior and two weeks after treatment. If a dark tan or sunburn is present, your treatment may be postponed.

_____ I understand that the effectiveness of my treatment is dependent upon the presence of melanin in my hair; therefore it will not be effective on white, gray, or blonde hair.

I have read and understood this agreement and all my questions have been addressed and answered to my satisfaction. I consent to the terms of this agreement.

Signature: _____

Witness: _____

Date: _____