High Intensity Focused Ultrasound Client Intake Form

General Information

Name		DOB
Address		
City	County	Post Code
Phone	Email	
Occupation		
Emergency Contact Name		Phone #
Would you like to be added to our email list for specials and discounts?	Yes ☐	No ☐
How did you hear about us?		

Medical History

Do you have any chronic medical conditions that we should know about?	Yes ☐	No ☐
If yes, please explain:		
Are you currently taking any medications?	Yes ☐	No ☐
If yes, please list:		
Do you have any allergies?	Yes ☐	No ☐
If yes, please list:		
Do you currently have cancer?	Yes ☐	No ☐
If yes, are you currently on chemotherapy?	Yes ☐	No ☐
Do you have any blood disorders?	Yes ☐	No ☐
Have you used retinoids in the last 3 days?	Yes ☐	No ☐
Have you used Accutane in the last 12 months?	Yes ☐	No ☐
Do you use anticoagulants or antiplatelet drugs?	Yes ☐	No ☐
Have you had Botox or fillers in the last 6 months?	Yes ☐	No ☐
Do you have cold sores?	Yes ☐	No ☐
Do you use immunosuppressant drugs?	Yes ☐	No ☐
Do you have type 1 or type 2 diabetes?	Yes ☐	No ☐
Do you have photosensitivity to sun exposure?	Yes ☐	No ☐
Have you had cancer in the past 12 months?	Yes ☐	No ☐
Do you have high blood pressure?	Yes ☐	No ☐
Do you have any cardiovascular conditions?	Yes ☐	No ☐
Do you have any medical devices implanted including, but not limited to, hearing aids, a pacemaker, or hormonal pellets?	Yes ☐	No ☐
If yes, please list:		
(Female clients) Are you currently pregnant or nursing?		
When was the first day of your last menstrual cycle?		

RF Microneedling

Consultation Form

Hifu FACIALS

Appointment date _____ *Appointment time* _____

Personal Information

FULL NAME

D.O.B. AGE: PHONE#:

ADDRESS:

To perform the Radio Frequency procedure in a safe manner, please answer the following health questions truthfully. We will keep all information disclosed in a confidential manner and will use it only for purposes of determining whether you are an ideal candidate for this procedure.

AREA(S) TO BE TREATED: ☐ Face ☐ Body ☐ Face + Body

MEDICAL HISTORY

- ☐ Y ☐ N Pregnant or nursing.
- ☐ Y ☐ N Pacemaker or internal defibrillator, implanted neurostimulators or another internal electric device.
- ☐ Y ☐ N Current or history of, cancer - especially skin cancer, or pre-malignant moles in treatment area.
- ☐ Y ☐ N Diabetes and Impaired immune system due to immunosuppressive diseases such as AIDS and HIV.
- ☐ Y ☐ N Immune suppressive medications.
- ☐ Y ☐ N Medications such as blood thinners.
- ☐ Y ☐ N Severe concurrent conditions such as cardiac disorders or epilepsy.
- ☐ Y ☐ N Condition which could be adversely affected by heat.
- ☐ Y ☐ N A history of diseases stimulated by heat, such as recurrent Herpes Simplex in the treatment area.
- ☐ Y ☐ N Chemical sensitivities such as reactions to cosmetic products or perfumes. If known, please list specific offending ingredients:

  .....
- ☐ Y ☐ N History of skin disorders such as keloid scarring, abnormal wound healing, as well as very dry and fragile skin.
- ☐ Y ☐ N Any surgical, invasive, ablative procedure in the treatment area before complete healing.
- ☐ Y ☐ N Any medical condition that might impair skin healing.
- ☐ Y ☐ N Areas of sensory impairment such as in cases of nerve lesions and neuropathies.
- ☐ Y ☐ N Any active condition in the treatment area, such as sores, psoriasis, dermatitis, eczema and rash as well as excessively/freshly tanned skin.

If getting the FACE treated:

- Dental implants, braces, caps, metal fillings (amalgams, gold). ☐
- Botox or filler in treatment area. ☐
- Active weeping acne. ☐
- Continuous use of Retin A, retinol or any other Vitamin A derivatives. ☐
- Herpes (active). ☐

If getting the BODY treated:

- Heavy menses/bleeding. ☐
- Metal implants or other implants in the treatment area- i.e. IUD, screws, plates. ☐
- Varicose veins in the treatment area. ☐

Absolute contraindications:

please choose what applies to you

- ☐ Implants: heart pace-maker, braces, cochlear implants
- ☐ Coagulation dysfunction or bleeding disorders
- ☐ Organ transplants
- ☐ Pregnancy
- ☐ Acute hernia, discopathy, spondylolysis
- ☐ Lactation
- ☐ Migraines or Epilepsy
- ☐ Tuberculosis
- ☐ Malignant Tumors
- ☐ Not feeling thermal changes
- ☐ Acute infections or inflammations
- ☐ A burn or care after such a burn
- ☐ Active cancer
- ☐ Botox or filler in treatment area
- ☐ Severe cardiovascular disease, circulation
- ☐ Accutane and retinol
- ☐ Suppuration of soft tissues
- ☐ Severe active arthritis
- ☐ Active gout Kidney stones
- ☐ Any active condition in the treatment area, such as troubles (thrombus arterial sclerosis, etc.) Herpes, sores, psoriasis, dermatitis, eczema and rash

If you answered YES to any of the above, please explain: .....

Please list any medications you are currently taking: .....

Client Name (Printed) ..... Client Signature ..... Date: .....

Therapist Name ..... Therapist Signature ..... Date: .....

What concerns would you like addressed today?

Treatment area:

By signing below, I agree to the following:

I have completed this form to the best of my ability and knowledge. I understand that this non-invasive treatment is not intended to produce the same results as an invasive surgical process. I understand that immediately after the session there may be a feeling of sagging and/or swelling. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

Client Printed Name	Signature	Date

Technician Name	Signature	Date

RF Microneedling

Informed Consent Form

THE TREATMENT

Radio Frequency is a non-invasive cosmetic procedure to help smooth, tighten, contour skin and temporarily reduce the appearance of cellulite. It can help treat sagging skin, lack of definition in the jaw line, loose jowls, sagging neck skin, wrinkles and fine lines. Radio Frequency uses electrical pulses to target and penetrate the under layer of skin using heat to stimulate collagen. The outer layer of skin is cooled during the process to avoid damage. During procedure you will feel a brief deep heating sensation.

RESULTS should be visible immediately and improve over a period of two to six months.

TREATMENT SITES include: Face, Area Surrounding Lip, Outer orbit area of the Eyes, Arms, Thighs, Tummy, Hands, Buttocks

SIDE EFFECTS rare but can include swelling, redness, bumps, minor burns and blisters on or around the treated area.

ALTERNATIVE PROCEDURES to Radio Frequency are Botox, Dermal Fillers, Laser and Surgery.

CONSENT

_____ I understand that taking the treatment course is my choice and that I am free to withdraw at any time, without giving any reason.

_____ I was told about the possible side effects of the treatment including: skin redness (erythema) and warmth.

_____ Although these effects are rare and expected to be temporary, any adverse reaction should be reported immediately.

_____ I understand that not everyone is a candidate for this treatment and results may vary.

_____ I confirm that I have read and understood the above information and will undergo the treatment out of my own free will.

_____ I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of a cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

_____ I understand that it is my personal responsibility to inform the clinician of any changes to my medical history during the course of Radio Frequency treatment sessions and I confirm that should this occur I shall advise the clinician of any changes I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

_____ FINANCIAL: I understand that all payments are due at time of service. To receive package prices, payment must be made for the entire package prior to service.

_____ CANCELLATION/Rescheduling Policy: Please be aware that all cancellations require a minimum of 24hrs notice. Failure to do so will result in that treatment being deducted from your course without a refund. It is important to be aware that this may have a negative effect on your overall results. Any changes to the initial treatment dates will be subject to availability.

ACKNOWLEDGMENT

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release _____ facility and staff, and specific technicians from liability associated with the procedure.

Client Name (Printed) _____ Client Signature _____ Date: _____

HIFU Consent Form & Liability Waiver

Please read and initial each of the statements below:

_____ I certify I am over the age of 18.
_____ I have voluntarily elected to receive high-frequency focused ultrasound after the nature and purpose of this treatment have been explained to me.
_____ I understand that the HIFU system delivers a low amount of focused ultrasound energy to the skin. The heat from the ultrasound stimulates new collagen to form.
_____ I understand that there can be discomfort during the treatment when the ultrasound energy is delivered.
_____ I have discussed with my practitioner the options available to me to optimize my comfort during the procedure.
_____ I understand that this non-invasive treatment is not intended to produce the same results as an invasive surgical process.
_____ I understand that immediately following the HIFU treatment, the skin may appear red for a few hours.
_____ I understand that It is not uncommon to experience slight swelling for a few days following the procedure or mild tingling and/or tenderness to the touch for days to weeks following the procedure.
_____ I understand that occasional temporary effects may include bruising or welts, which resolve in hours to days, or numbness in a select area, which resolves in days to weeks.
_____ I understand that as with any medical procedure, there are possible risks associated with the treatment. There is a remote risk of a burn that may or may not lead to scarring (either of which will respond to medical care), or temporary nerve inflammation, which will resolve in a matter of days to weeks. Temporary local muscle weakness may result after treatment due to inflammation of a motor nerve. Temporary numbness may result after treatment due to inflammation of a sensory nerve.
_____ It has been explained to me that the results vary from patient to patient, and, occasionally, the collagen-building on the inside that helps counter the effects of gravity does not have a visible effect on the outside. I understand that results will unfold over the course of 3 to 6 months and that some patients may benefit from more than one treatment.
_____ I understand that the following conditions preclude me from having this treatment at this time and verify that none of the following conditions apply to me at this time:

- Cardiac issues
- Cancer
- Infected, inflamed, or swollen skin
- Blood diseases
- Coagulation problems
- Metallic implant (pacemaker)
- Pregnant/Lactating

_____ I have, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. I agree I will assume the risk and full responsibility for any and all injuries, losses, side effects, or damages that might occur to me while I am undergoing this procedure. I do not hold the technician responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

I now authorize _____ to begin my HIFU treatment.

_____	_____	_____
Name Printed	**Signature**	**Date**

_____	_____	_____
Technician Name	**Signature**	**Date**

Body Measurements Tracker

Pre-treatment measurements

Date: .....

Neck	Arm	Chest	Waist	Hips	Weight	BMI	BF%	VF

	Neck	Arm	Chest	Waist	Hips	Weight	BMI	BF%	VF
Session 1 Date:									
Session 2 Date:									
Session 3 Date:									
Session 4 Date:									
Session 5 Date:									
Session 6 Date:									
Session 7 Date:									
Session 8 Date:									
Session 9 Date:									
Session 10 Date:									
Session 11 Date:									
Session 12 Date:									

HIFU Pre Care - Post Care

HIFU Pre Care

- Avoid Accutane 12 months prior to HIFU treatments.
- If you are prone to cold sores, take an antiviral agent 2 days prior to and the day of the treatment.
- Do not use topical agents that may increase the sensitivity of your skin (e.g. retinoids, exfoliants, topical antibiotics, or acids) within 7 days of your treatment.
- Do not wax, do electrolysis, or use depilatory creams within 7 days of your treatment.
- Avoid fillers and Botox
- Avoid blood-thinning medications.
- Avoid sun exposure and/or IPL/laser treatments prior to your HIFU procedure.
- Avoid anti-inflammatory medications such as Advil or Ibuprofen.

Day of Preparation

- Come to your appointment with clean skin.
- Avoid caffeine and alcohol the day of and for 48 hours prior to your treatment.
- Wear a top with a wide neck if treating the face/neck.

HIFU Post Care

- Always wear sunblock (SPF 30 or higher).
- Makeup may be applied immediately following the procedure.
- Avoid anti-inflammatory medications such as Advil or Ibuprofen for 1 week after the procedure.
- Do not use ice on the treated area.

Day 1-3

- Redness and swelling are normal.
- It is common for a blister or bruise to develop. If you develop a blister you may use atopical antibiotic ointment until it is healed.
- Avoid heat and strenuous exercise including hot tubs, hot showers/baths, saunas, etc.
- Use gentle skin cleaners.

Day 1-3

- You may resume your normal skin care routine including waxing, tweezing, anddepilatory creams.

RF Microneedling Skin Tightening

Pre-treatment Advices

- **Do NOT** undergo the procedure if you have a PACEMAKER, INTERNAL DEFIBRILLATOR, OR ANY ACTIVE IMPLANTED DEVICE.

- **Do NOT** undergo any skin peel or laser procedures for 2 weeks prior to the procedure.

- **Do NOT** wear any make-up, lotions, or creams on the treatment area on the day of treatment.
- If you have a history of cold sores, please **DO** let the nurse or physician know.

- **DO** hydrate well the day of and day after treatment as this will result in a more comfortable and effective treatment.

- *For male clients:* arrive at the appointment clean shaved.

What to Expect

- *Most clients experience mild heat and redness following treatment (similar to sunburn), which usually resolves quickly. You may wear a mineral based foundation to conceal any redness.*
- *Swelling rarely occurs and usually diminishes within 24-48 hours.*
- *Most people find that they can return to work and resume normal activities immediately after treatment.*
- *RF heats the skin to cause retraction of the collagen fibers, so it is important not to cool it immediately afterwards as the inflammation encourages results. If you have any concerns, or feel your skin may be heating excessively, please contact your treatment clinician.*

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High Intensity Focused Ultrasound FAQs

What is High-Intensity Focused Ultrasound (HIFU)?

HIFU is a system for skin lifting, with high-intensity ultrasound technology, which regenerates the skin of the face, neck, and/or décolleté making it more toned, compact, and smooth without scalpels or needles.

How does High-Intensity Focus Ultrasound (HIFU) work?

The HIFU system delivers a low amount of focused ultrasound energy to the skin. The heat from the ultrasound stimulates new collagen to form.

How long is a High-Intensity Focused Ultrasound (HIFU) session?

On average, each session lasts between 45 and 60 minutes.

What are the potential side effects of High-Intensity Focused Ultrasound (HIFU)?

In some cases, there is a reddening of the hair on the treated area, but this effect disappears after a few hours. Other effects include but are not limited to swelling on the treated area, tingling, and/or sensitivity to touch.

How many High Intensity Focused Ultrasound (HIFU) sessions will I need?

The number of sessions will vary from patient to patient, but on average a client will need two to three sessions.

Will it hurt?

The treatment itself is painless, although some patients experience discomfort. What is most noticeable is a sensation of temperature

What are the advantages of High-Intensity Focused Ultrasound (HIFU)?

- A minimal number of sessions to see results.
- It does not damage the epidermis.
- It does not require incisions or injections.
- It acts both in-depth and on the surface.
- It does not require a recovery period.
- The result is natural.
- It is not painful;
- It is suitable for all skin types.

What results can I expect?

Results vary from person to person and are not guaranteed, but generally, people perceive an immediate tone and compactness of the face that will gradually improve up to 6 months after treatment.

How long will the results last?

The first visible results emerge after 60-90 days and are maintained for 1-2 years.

RF Microneedling Skin Tightening

Aftercare Advices

- DO hydrate well after treatment as this may produce a better result.
- DO NOT vigorously rub the skin after treatment, DO gently wash your face and continue with your usual skincare routine.
- DO wait 7 days before resuming the use of Retin-a (tretinoin), Renova, Differin, Tazorac, Ziana, Veltin, Atralin, glycolic acids or any other exfoliating agents such as a Clarisonic Brush.
- Do NOT undergo laser treatments, chemical peels, waxing, the use of depilatories, or microdermabrasion for 3-4 weeks after treatment.
- DO expect some possible tenderness, swelling, warmth, and redness on the treated areas for a few days to a week after treatment.
- DO sleep on two pillows for the first 24-48 hours post treatment to decrease swelling
- Exercise, swimming, spas and anything that involves increasing your body temperature, should be avoided for 24-48 hours.
- DO schedule your next treatment as 2-4 treatment intervals of 1-2 weeks maximizes results.

We want you to have an outstanding result. If you have any questions or unexpected concerns, please call our office for assistance.

RF Microneedling Skin Tightening

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APPOINTMENT CANCELLATION POLICY

Dear Client,

We strive to render excellent care to you and the rest of our clients. Your care and treatment is a priority for us. We also ask that you respect your specialist's time and expertise as well.

In an attempt to be consistent with this, we have a Cancellation Policy that allows us to schedule appointments for our clients, with respect for your time, the next client's time, and the specialist's time.

Our policy is as follows:

We request that you give a notice **not later than 24 hours** prior your scheduled appointment in the event that you can not make it. If the client misses an appointment without contacting us, it is considered a missed or "No Show" appointment. Additionally, if a client is more than 15 minutes late for an appointment, it will be considered as " No Show" appointment, and that appointment will be rescheduled. Also, if you miss more than 3 (three) appointments, we reserve the right to charge you a fee of _____.

A _____ non refundable deposit will be paid at time of making appointment and will be taken off at the time of the appointment.

If you have questions regarding this policy, please let us know, and we will be happy to clarify our policy for you.

I have read and understand the Appointment Cancellation Policy, and I agree to be bound by its terms. I am aware that my credit card will be charged for the missed appointment, and I agree to this terms.

I, _____ , have received the copy of Cancellation Policy.

Date: _____

Client Name (Printed) _____

Client Signature _____

COVID-19 LIABILITY RELEASE WAIVER

THIS FORM MUST BE COMPLETED AND SIGNED BEFORE TREATMENT

The World Health Organization has declared the novel Coronavirus (COVID-19) a worldwide pandemic. Due to its capacity to transmit from person-to-person through respiratory droplets, the government has set recommendations, guidelines, and some prohibitions which _____ adheres to comply.

Symptoms of COVID-19 include:

- Fever
- Fatigue
- Dry Cough
- Difficulty Breathing

I agree to the following:

- ☐ I, nor members of my household, have not experienced any of the symptoms listed above within the last 14 days.
- ☐ I, nor members of my household, have not travelled internationally in the last 30 days.
- ☐ I, nor members of my household, do not believe that we have been exposed to someone with a suspected and/or confirmed case of the Coronavirus (COVID-19).
- ☐ I, nor members of my household, have not been diagnosed with the Coronavirus (COVID-19) within the last 30 days.
- ☐ The venue cannot be held liable from any exposure to the Coronavirus (COVID-19) caused by misinformation on this form or the health history provided by each client.
- ☐ I understand that due to the frequency of visits of other clients, the characteristics of the virus, and the characteristics of these services that I have an elevated risk of contracting the virus simply by being in the establishment.

To prevent the spread of the contagious virus and to help protect each other, I understand that I must follow the establishment's guidelines:

- Reschedule appointment if you are feeling unwell;
- No additional guest is allowed;
- Wearing a mask is required upon arrival and during the entire procedure;
- Wash hands upon arrival;
- Limit conversation during the procedure.

By signing below, I agree to each above statement and release the venue and its employees from any and all liability for the unintentional exposure or harm due to Covid-19 and other communicable conditions.

Date: _____

Client Name (Printed) _____

Client Signature _____

PHOTO & VIDEO RELEASE FORM

I, _____ , hereby grant and authorize _____ the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all pictures, video, and/ or audio taken of me to be used in and/ or for any lawful promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, press kits, websites, social media sites and other print or digital communications without payment or any other consideration.

This authorization extends to all languages, media, formats, and markets now known and later discovered.

I will be consulted about the use of the photograph and/ or video recording for any purpose other than those listed below:

- promotional materials;
- printed and/ or digital advertisements;
- educational presentations or courses;
- informational presentations;
- online educational courses;
- educational videos;
- social media posts.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Date: _____

Client Name (Printed) _____

Client Signature _____