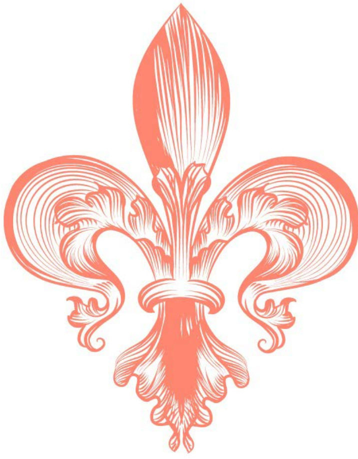

Ageless in the Triad

SculpSure Intake Form

Thank you for choosing Ageless in the Triad for your Body Treatments.
Please answer the following questions so that our Therapists
may better understand your goals for the treatment.

Medical History Form

Last Name: ______________________ First Name: ______________________

Address: ______________________

City: ______________________ State: ______________ Zip Code: ______________

Telephone: Home: ______________ Work: ______________ Cell: ______________

Date of Birth: ______________________ Sex: Male: ________ Female: ________

Email: ______________________

Family Doctor: ______________________ Phone: ______________

Pharmacy: ______________________ Phone: ______________

Emergency Contact: ______________________ Phone: ______________

Which body area/areas or condition would you like treated?

____

____

____

Please answer all of the following questions

1. Do you have **ANY** current or chronic medical illnesses? **Yes□ No□**

   Disclose any history of heat urticarial, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or ANY other condition or illness.

   Please List:

____

____

2. Do you have **ANY** current or chronic skin conditions? **Yes□ No□**

   Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos Syndrome, scleroderma, skin cancer, or any other skin condition.

   Please List:

____

____

3. Are you currently under a doctor's care? If so, for what reason? **Yes□ No□**

____

4. Do you take/use ANY medications (prescription and nonprescription), vitamins, herbal, or natural supplements, on a regular or daily basis? **Yes□ No □**

Please List:

____

____

5. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? Yes□ No □

Please List:

____

____

Informed Consent Form

The SculpSure™ delivers laser energy to heat the deep layer of fat. The heat that s created damages the fat cells. The damaged fat cells are then eliminated by the body through your lymphatic system.

During the laser delivery the applicators cool the skin throughout the entire treatment. The cooling protects your skin while the energy heats your fat layer. When the treatment begins, it will feel warm, and over time the heat sensation will increase to short periods of intense deep heat. You may also experience some cramping, tingling, prickling or squeezing sensations deep in the fat layer. These sensations are normal and expected. These sensations indicate that the laser is effectively targeting and damaging the fat layer.

- The SculpSure is eye safe. There is no need to wear protective eyewear.
- Your skin may be slightly pink to red immediately after treatment. This may last for a few hours.
- Following the SculpSure treatment you may experience some swelling, tenderness, firmness or hardness at the treatment site. This usually resolves within 2 weeks but may last longer.
- The treated areas should be massaged two (2) times a day for five to ten (5 to 10) minutes. There are no lifestyle restrictions following your SculpSure treatments. It is recommended to increase your water intake after treatment.
- You may use ice packs or Tylenol according to packages instructions to help ease tenderness.
- I have been thoroughly and completely advised regarding the end point of the procedure. I understand that the practice of medicine is not an exact science and no results have been guaranteed. I acknowledge that the results may not meet my expectations. I certify that no guarantees have been made by anyone regarding the procedure(s) that I have requested and authorized.
- There is no guarantee that the expected or anticipated results will be achieved.

I have been informed that firmness, hardness, nodules, redness, tenderness, swelling, pain, and bruising are the most common side effects. Other less common side effects which can occur are itching, skin contour irregularities, dimpling, hyperpigmentation/hypopigmentation, asymmetry, necrosis, changes in skin laxity, numbness, blister or burn. **Yes □ No□**

I confirm that I have not had sun exposure, or used tanning beds, sunless tanner or spray tans within the last 7 days. **Yes□ No□**

Before and after treatment instructions have been discussed with me. The procedure, potential health benefits and risks, and alternative treatment options have been explained to my satisfaction. **Yes□ No□**

I have read and understand all information presented to me before consenting to treatment. I have had all my questions answered.

Consent for treatment of ____

Client: ______________________________________ Date: ______________________________

Witness: _____________________________________ Date: ______________________________

Physician: ___________________________________ Date: ______________________________

I have acknowledged that all the information provided by me is true and correct to the best of my knowledge. I also understand that some skin conditions may require more than one treatment and home care products to achieve the results desired. I hereby release Ageless in the Triad from any liability pertaining to treatments, understanding that results cannot be guaranteed due to individual skin type(s) and condition(s)

Cancellation Policy

As a courtesy to our spa professionals, please provide a minimum of 24 hours' notice should you need to cancel or reschedule an appointment. There will be a charge of 50% of scheduled services for cancellations of less than 24 hours' notice. If you have a series, one service from this series will be deducted. For filler appointments, a $100 deposit will be taken when scheduling the appointment and will be applied toward the filler service. However, if you fail to show for your appointment, we hold the right to keep the deposit. By scheduling an appointment, you are agreeing to our cancellation policy. Cancellations for Monday appointments are required to be cancelled by Friday at 4PM. When booking an appointment, a credit card will be needed to hold the appointment. We take Visa, MasterCard, Discover, American Express and Care Credit. We thank you for your understanding.

Late Policy

Your appointment time is reserved exclusively for you! If your arrival time is 15 minutes or later than your scheduled appointment, this may result in a shortened appointment. We reserve the right to reschedule your appointment.

No Show Policy

There will be a charge of 50% of scheduled services. If you have a series; one service from this series will be deducted. If you have a gift card, the amount will be deducted from the gift card. For Botox/Dysport patients, a $50 fee will be charged to your credit card for missed appointments or reoccurring late cancellations.

Payments/Refunds

Payments for all procedures at Ageless in the Triad are due at the time of service and are non-refundable. All sales are final. However, Ageless in the Triad does have an exchange policy that gives you options if the need arises. Should you wish to discontinue your treatments in the midst of a series, you will receive pro-rated credit for the unused treatments. The treatments that have already been provided will be charged at current single treatment prices to calculate the remaining credit. This credit may be used to purchase other treatments, not products, offered at Ageless in the Triad.

Client Signature ____ Date __________________

Reviewed By ____ Date __________________

Patient Communication Directive with Individuals Involved in Your Care

PATIENT IDENTIFICATION

NAME: ____

DATE OF BIRTH: ____

Please list all individuals who may be involved in coordinating your care, payment of your care, or to whom we may provide the details of your care.

Name	Relationship to Patient
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________

NOTE: We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify us if you wish to alter the designations above.

Patient Rights:

- I have the right to revoke this authorization at any time by contacting this office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and know that my treatment will not be conditioned on signing.

Signature of Patient/
Legal Representative: ____ Date: _____________

Relationship to Patient: ____

To revoke this authorization, please send a written request to:

Practice Manager
Ageless in the Triad, PC
900 Old Winston Road, Suite 204B
Kernersville, NC 27284