

# LA BELLA DONA SKIN CARE

## INFORMED CONSENT HARMONY HAIR REDUCTION

CLIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK NUMBER \_\_\_\_\_

CELL NUMBER \_\_\_\_\_ CELL PROVIDER \_\_\_\_\_ DOB \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_ REFERRED BY \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to perform the Harmony Hair Reduction procedure and any other measures which in their opinion may be necessary.

I understand that the Harmony is a device used for hair reduction and that clinical results may vary in different skin types and hair types. I understand there is possibility of short-term effects such as reddening, blistering, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me \_\_\_\_\_ (client's initials).

Clinical results may vary depending on individual factors, including medical history, skin and hair type, client compliance with pre/post treatment instructions, and individual response to treatment. I understand that the Harmony system is a safe alternative to methods used for removing unwanted hair, such as shaving, waxing, chemical and electrolysis.

I understand that treatment by the Harmony hair removal system involves a series of treatments and the fee structure has been fully explained to me \_\_\_\_\_ (client's initials).

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcome and possible complications; I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so. I understand this treatment will not work on light hair (blonde, gray, etc.). Your money will not be refunded.

I confirm that I am not pregnant at this time, and that I have not taken Accutane within the last 6 months. I do not have a pacemaker or internal defibrillator.

I consent to the taking of photographs and authorized their anonymous use for the purposes of medical audit, education and promotion.

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.

Client Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

As a client, you will be provided with the opportunity to review your treatment with the 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 \_\_\_\_\_ has reviewed treatment with you and answered your questions. Your attending professional esthetician will review this form with you a second time prior to your initial treatment and will sign this form in the space provided to indicate that you have been given a second opportunity to ask questions.

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\_\_\_\_\_ 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 recommends by \_\_\_\_\_ should be followed.

\_\_\_\_\_ I understand 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 visible results, that each case is 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. (HIV positive, Hepatitis A or Hepatitis B)

\_\_\_\_\_ I understand that direct sun exposure is prohibited while I am undergoing treatment. The use of sun block 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 Overtax.

\_\_\_\_\_ I agree to refrain from any skin care treatment, cosmetic or medical, 14 days preceding and 14 days following any treatment with \_\_\_\_\_ including filler injections and BOTOX\* Cosmetic treatments.

\_\_\_\_\_ I understand that I will not be allowed to have treatments during any pregnancy. My unused treatment fees will be refunded or the unused portion will be placed on hold.

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.

Please list any illness we would need to know about

Client Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

I, the undersigned professional, certify that I have reviewed the foregoing treatment consent with the named client (including the risks of any alternatives to treatment) on or prior to the first date of treatment and have given the client the opportunity to ask questions regarding his or her treatment, including the opportunity to communicate with a physician.

Esthetician  
Professional: \_\_\_\_\_ Date: \_\_\_\_\_

In the event that you and your esthetician decide to do one of the three peels: (micro peel, micro peel plus or LHA, it is important to understand that even though the chances are slim, there could always be adverse effects. I \_\_\_\_\_ (int.) understand that while the benefits of the peels are to smooth fine lines, help with skin discoloration, reduce the appearance of acne scars and environmental damage to the skin, there could be risks in rare cases, that may occur in connection with this particular procedure.

The foregoing list is not intended to be a complete or exhaustive list of all possible problem or complications, which may arise as a result of the Clinical procedure. Should one or more of the foregoing complications arise, please notify us immediately.

**Discomfort:** is generally minimal and subsides after a sort duration

**Swelling:** is unusual, but if it occurs, it will be minimal. Swelling subsides in a few hours to a few days

**Reddening:** or a red discoloration may persist anywhere from a few days to several weeks

**Demarcation:** is a difference in color, texture, pigmentation that may occur at the junction between the treated and non-treated skin areas. This is unusual with epidermal Clinical procedures

**Existing Blemishes:** or moles, blood vessels (telangiectasias), freckles and sun spots may become more obvious and darker since layers of dead skin have been removed

**Eye Injury:** caused by chemical getting into the eye, scarring and vision disturbances may occur.

Protective safety goggles are recommended to be worn by you, the client, while chemicals are being used during all Clinical procedures

**Scarring:** is very unusual, but may occur

**Pigmentation:** is rare and usually temporary. Possible permanent changes in the color of the skin could occur

**Milia:** may occur, but will usually disappear quickly

**Infection:** is extremely unlikely, but may happen. An outbreak of herpes may occur in effected individuals (if you are prone to cold sores, ask your physician for medication)

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**Signature**

If you cannot make your scheduled appointment, please notify us within 24 hours or one half of your service will be charged to you.