



BEAUTY, HEALTH & WELLNESS

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HydraFacial MD Consent Form

Treatment Consists of:

HYDRAFACIAL MD, RED/BLE LIGHT THERAPY, LYMPHATIC DRAINAGE THERAPY, AND/OR WET DIAMOND AGGRESSIVE ABRASION.

INITIALS _____

Medical Information: *Please circle all that pertain to you.*

- | | | |
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| <ul style="list-style-type: none">• ACCUTANE• ALLERGIES• AUTOIMMUNE DISEASE, HIV, LUPUS, HEPATITIS OR EPILEPSY.• BOTOX/DYSPORE WITHIN THE PAST 2• CANCER OR POST-CANCER TREATMENTS• CORTISONE/STEROID INJECTIONS• COSMETIC INJECTIONS/FILLERS WITHIN PAST TWO WEEKS• DIABETES• ECZEMA/PSORIASIS EPILEPSY• HIGH/LOW BLOOD PRESSURE• LYMPHATIC DISORDER• THYROID CONDITION | <ul style="list-style-type: none">• FACIAL WAXING WITHIN THE PAST 7 DAYS• ROSACEA• RETIN A WITHIN 5-7 DAYS OF TREATMENT• SKIN ABRASIONS OR LESIONS• STAGE 3 OR 4 ACNE• SKIN LIGHTENING OR BLEACHING CREAMS• SUNBURN• RECENT LASER PROCEDURES OR CHEMICAL PEELS• BLOOD THINNER MEDICATION• UNDER MEDICAL CARE | <p>WEEKS</p> <p>THE</p> |
|---|---|-------------------------|

Acknowledgements: *Please initial all statements.*

- I ACKNOWLEDGE THAT I HAVE NOT USED ACCUTANE OR ANY MEDICATION USED FOR THE SAME PURPOSE DURING THE LAST 12 MONTHS. INITIALS _____
- I ACKNOWLEDGE THAT IF I HAVE EVER HAD A COLD SORE OR FEVER BLISTERS, I SHOULD CONSULT WITH MY PHYSICIAN OR PHARMACIST FOR A PRE-USE MEDICATION TO HELP AVOID A POSSIBLE OUTBREAK. INITIALS _____
- I ACKNOWLEDGE THAT I SHOULD AVOID USE OF PRODUCTS CONTAINING GLYCOLIC ACID OR ANY RETIN A PRODUCTS FOR 1- 2 WEEKS AFTER TREATMENT. INITIALS _____
- I ACKNOWLEDGE THAT I AM NOT PREGNANT OR BREASTFEEDING. INITIALS _____
- I ACKNOWLEDGE THAT THIS PROCEDURE IS STRICTLY AN ELECTIVE COSMETIC PROCEDURE AND THAT NO MEDICAL CLAIMS HAVE BEEN EXPRESSED OR IMPLIED. INITIALS _____
- PHOTOGRAPHS MAY BE TAKEN FOR COMPARISON OF FUTURE TREATMENTS FOR MY MEDICAL CHART. INITIALS _____

I HAVE READ THE ABOVE AND UNDERSTAND IT. MY PROVIDER HAS ANSWERED MY QUESTIONS SATISFACTORILY. I ACCEPT THE POSSIBLE RISKS AND COMPLICATIONS OF THE TREATMENT.

PATIENT SIGNATURE_____ DATE_____
WITNESS_____DATE_____

*THANK YOU FOR CHOOSING AND TRUSTING MIRABILE MD. BEAUTY, HEALTH & WELLNESS FOR YOUR
AESTHETIC NEEDS.
PLEASE FEEL FREE TO CALL (913) 888-SKIN (7546) IF YOU HAVE ANY QUESTIONS*