



# HydraFacial MD Consent Form

Treatment Consists of:

HydraFacial MD, Red/Blue light therapy, Lymphatic Drainage Therapy.

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

- Accutane use within the past 12 months
- Allergy to shellfish
- Autoimmune disease, HIV, lupus, hepatitis or epilepsy.
- Botox/Dysport/Daxxify or other neurotoxin treatment within the past 2 weeks
- Cancer or post-cancer treatments
- Cortisone/steroid injections
- Cosmetic injections or dermal fillers within the past 2 weeks
- Diabetes
- Eczema/psoriasis
- High or low blood pressure
- Lymphatic disorder
- Thyroid condition

**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 \_\_\_\_\_

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 \_\_\_\_\_

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

