EPIPHANY Spa

***All patients must sign a consent form before any treatment.**

For Hair Reduction, Skin Rejuvenation, Pigmented lesions, Vascular lesions, and Acne.

Name: _____ Date: _____

I authorize you to perform a Pulsed Light System procedure. I am aware that these treatments are intended to result in hair reduction, skin rejuvenation, or improvement of pigmented and vascular lesions and acne.

I understand and accept that it is necessary to conduct more than one treatment in order to achieve results. I also accept that it may be necessary to use other manners of treatments, including skin care products, needed to blend color reduce sun damage and more.

The skin treated will be red and swollen for a period of time, with the forming of fine, thin scabs. Keep the treated areas covered with Aloe Vera gel and soothing creams until the thin scabs fall off. This process will take between 1- 3 weeks. It could take as long as 3-6 months in some rarer cases. Do not scratch the scabs, as scarring may result.

We are unable to treat clients who are taking ACCUTANE and PHOTOSENSITIZING medications.

Client must fill in a medical history form which must be updated if any changes occur during the treatment period.

The following problems may occur with treatment:

1. Scarring: The pulsed light system can create a bruising and a moderate burn or blister to the skin. For an effective treatment, the intensity (joules) must be just below the blistering point which means that the skin will be red (erythema). There is a risk of scarring in burned skin cases.

2. Hyperpigmentation and hypopigmentation have been noted to occur after treatments, especially with a darker complexion. This usually resolves within weeks, but it can take as long as 3-6 months in some cases. Permanent color change is a rare risk. If you have dark skin, a skin lightening cream may be advised to reduce the melanin in your skin before the treatment. Avoiding sun exposure before and after the treatment is crucial to reduce the risk of color change and burns.

3. Infection: Although infection following pulsed light treatment is unusual, bacterial, fungal, and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a treatment. This applies to individuals with a past history of Herpes simplex virus infections in the area. Should any type of skin infection occur, additional treatment including antibiotics will be necessary.

If you have a history of Herpes simplex virus in the treated area, we recommend preventive therapy.

4. Bleeding: Pinpoint bleeding is rare but can occur following pigmented and vascular lesion treatment procedures. Should bleeding occur, additional treatment might be necessary.

5. Skin tissue pathology: Energy directed at skin lesions may potentially vaporize the lesion. Laboratory examination of the tissue specimen may not be possible. Only clearly benign pigmented lesions can be treated. Check with your doctor for a clearance for the treatment.

6. Allergic reactions: In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations have been reported. Systemic reactions (which are more serious) may result from prescription medicines. Allergic reactions may require additional treatment.

7.Wear sunscreen of SPF 50 or higher before and after treatment to protect your skin. We highly recommend you use sunscreen at all times.

8. I understand that exposure of my eyes to light could harm my vision. I will keep the eye protection on at all times during the treatment session.

9. Compliance with the after-care guidelines is crucial for healing, prevention of scaring, hyper-pigmentation, and hypopigmentation. Occasionally, unforeseen mechanical problems may occur, and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if any inconveniences occur.

ACKNOWLEDGEMENT

I authorize you to perform a Pulsed Light System procedure and understand that procedures may be modified to ensure my safety and the safety of others during Covid – 19. I agree that the clinic has taken all the necessary precautions to provide me with a safe treatment and I consent to being in close parameters with my technician in accordance to the measures put in place. I understand that the Clinician reserves the right to terminate the treatment immediately if I show symptoms of feeling unwell.

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and understand the risks. I hereby release (individual) and (facility) and (doctor) from all liabilities associated with the above indicated procedure.

Client/Guardian Signature _____

Date _____

Practitioner Signature _____

Date _____