Microcurrent/LED Therapy Consent Form

Client Name: _____

Microcurrent facial toning is a non-invasive, low level current of electricity that mirrors the body's own natural electrical impulses that stimulate ATP (adenosine triphosphate) which contributes to the body's healing and rejuvenating powers. This results in strengthening, firming, toning, and relaxing of the muscles. Improved blood flow increases the supply of nutrients to the tissue and muscle fibers. By improving blood circulation, the overall health, function, and appearance of the skin is enhanced. LED Light Therapy is a non-invasive procedure that activates skin cells with non-thermal light energy. LED Light Therapy converts light energy to metabolic energy, boosting energy to the cells and accelerating healing. While the skin receives a benefit from a single treatment, a series of treatments are recommended to see an aggregate improvement. Ideally, treatments will begin weekly for eight weeks and then maintained at regular intervals of once per 4-8 weeks. This is a treatment that builds upon itself similar to working out once compared to working out week after week.

Have you ever had any of the following:

Acute or Cutaneous Porphyria: □YES □NO
Lupus Erythematosus: □YES □NO
Thyroid Problems: □YES □NO
Photophobia: □YES □NO
Exogenous Eczema: □YES □NO
Epilepsy or Seizures: □YES □NO
Hypomelanism (albinism): □YES □NO
Pacemaker/Defibulator: □YES □NO
Do you take blood thinners? □YES □NO
Do you take anabolic steroids? □YES □NO

Skin Cancer: □YES □NO
Eye disease/retinal abnormalities: □YES □NO
Migraines: □YES □NO
Asthma: □YES □NO
Heart trouble/pace maker: □YES □NO
Diabetes: □YES □NO
Thrombosis or phlebitis: □YES □NO
Metal Implants: □YES □NO
Do you take Auranofin (Ridaura®)? □YES □NO

Please carefully look over the following list of medications and check off any you have taken in the past 7 days. These medications have been known to cause light sensitivity and it is recommended that you suspend the medications for 5-7 days before undergoing light therapy.

Please be sure to check with your doctor before discontinuing any prescribed medications.

□ Acne Oral: **Isotretinoin** (Accutane®, Accure®, Aknenormin®, Amnesteem®, Ciscutan®, Claravis®, Isohexal®, Isotroin®, Oratane®, Sotret®, Roaccutane®)
Topical Isotretinoin (Isotrex®, Isotrexin®)
Tretinoin (Retin-A®, Atrolin®, Avita, Refissa®, Renova®

□ Anabolic Steroids: **Testosterone** (Depo-Testosterone®, Delatestryl®, Natesto®, Axiron®, AndroGel®, Androderm®, Fortesta®, Striant®, Testim®, Testopel®, Aveed®, Vogelxo®)
Oxandrolone (Oxandrin®)

□ Anti-Arrhythmic: **Amiodarone** (Pacerone® Cordarone® Aratac®)

Chlorpromazine (Thorazine®, Chloramead®, Chlordryprom®, Chlor® Promanyl®, Largactil®, Promapar®, Promosol®, Terpium®, Sonazine®)

□ Anti-Psychotic: **Haloperidol** (Haldol®)
Trifluoperazine (Stelazine®, Novoflurazine®, Pentazine®, Solazine®, Terfluzine®, Triflurin®, Tripazine®)

□ Anti-Fungal: **Griseofulvin** (Grifulvin®)

□ Antibiotics: **Tetracycline** (Helidac®, Terra-Cortril®, Terramycin®, Sumycin®, Actisite®, Bristacycline®, Actisite®, Tetrex®, Doxycycline®, Ciprofloxacin®)
Norfloxacin (Noroxin®, Quinabic®, Janacin®)
Ofloxacin (floxin®, Oxaldin®, Tarivid®)
Nalidixic Acid (NegGam®, Wintomylon®)
Ciprofloxacin (Cipro®, Ciproxin®, Ciprobay®)
Minocycline (Minomycin®, Minocin®, Arestin®, Akamin®, Aknemin®, Solodyn®, Dynacin®, Sebomin®)
Oxytetracycline
Demeclocycline
Lymecycline

□ Anticoagulants: **Warfarin** (Coumadin®)
Clopidogrel Bisulfate (Plavix®)
Rivarixaban (Xarelto®)
Apixavan (Eliquis®)
Edoxaban (Savayasa®)

□ Cancer: **Methotrexate** (MTX®, Aminopterin®, Ledertrexate®)

Please list any additional medications NOT listed above, herbs, supplements, and over-the-counter medications you may currently be taking or have taken in the past 7 days:

_____
_____
_____

I hereby certify I do not have any of the above conditions, devices, and implants. I also certify that I do not take any of the above medications. I have provided truthful responses on this form. I understand that failure to disclose health information may impact my treatment, bodily response, and results.
Client initial _____

Authorization and Consent:

I hereby authorize Skinology, LLC to perform Microcurrent/LED Lift procedure on me. I fully understand this procedure has limited applications, different bodies have different responses, and no specific results are guaranteed. No guarantee has been expressed or implied. I realize there may be certain risks

involved with this treatment and I may experience side effects after the procedure has been performed. I agree to release and waive Skinology, LLC's liability if such results or complications occur. I further understand my failure to follow post-care instructions may lead to undesired results and complications. I acknowledge I have had the opportunity to ask questions, and I fully understand the treatment of the Microcurrent/LED Lift procedure. I understand I am responsible for all costs of the procedure and related treatments. No refunds will be given for treatments received.

Client Signature	Printed Name	Date

Witness Signature	Printed Name	Date