SkinSheek LIFT Consent

Name: _____ DOB: _____
Address:_____
Cell Phone: _____ Email:_____

I hereby consent and authorize Kathleen Cauthen, a licensed esthetician and SkinSheek Certified Technician, to perform a procedure using the SkinSheek LIFT machine on the following body part(s):
_____
_____

_____ I acknowledge that the treatment goal is for esthetic improvement. It has been explained to me that independent results may vary and occasionally, the collagen building on the inside that helps counter the effects of gravity does not have a visible effect on the outside.

_____ I understand results will unfold over the course of 3-6 months and that it may take more than one treatment to reach my treatment goals.

_____ I understand that a non-invasive is not intended to produce the same results as an invasive surgical procedure.

_____ I have not had Botox in the past 3-6 months or used retinoids for 3 or more days.

_____ I am not on any blood thinners or high doses of aspirin.

_____ I am not/have not taken the following prescription drugs: Accutane or similar drug (within the last 12 months), anticoagulants or antiplatelet drugs, or immunosuppressant drugs.

_____ I have been informed the heat from the ultrasound stimulates new collagen to form. I understand there can be discomfort during treatment when the ultrasound energy is delivered. I understand there are available comfort options and will advise if the discomfort is more than 5 on a 10-point pain scale. I understand there is a possibility for burns to occur which may or may not produce scarring.

_____ I understand that following treatment, skin may appear red for a few hours. It is not uncommon to experience slight swelling for a few days and/or tingling/tenderness to touch for days to weeks. To date no permanent injuries to facial nerves have been reported.

_____ I understand occasional temporary effects may include bruising or welts which resolve in hours to days, or numbness in a select area which resolves in days to weeks.

_____ I do not have currently or prior history of: active severe or cystic acne, open wound or lesion on area being treated.

_____ I do not currently or have a prior history of: Bell's Palsy, hemorrhagic or bleeding disorders, epilepsy, diabetes, keloid scarring, herpes or cold sores, autoimmune disease, or active or local skin disease that may affect wound healing.

_____ I do not have any questions concerning and agree to follow the post-treatment care and home instructions that have been given to me.

_____ I understand that numbing is optional.

_____ I understand I need to inform if I have had any facial skin tightening procedure within the last year, or if I have had ablative or non-ablative resurfacing laser treatment, dermabrasion and/or deep facial peels, or lipoplasty.
____ I have had one of these procedures ____ I have not had any of these procedures.

_____ I do not have lupus, heart disease, high blood pressure, unhealed surgical wound, any disfunction that suppresses my ability to feel heat or pain. I do not have a pacemaker, defibrillator, or any metal prosthetic in my body.

_____ I have not had surgery at the treatment area for three months prior to this treatment.

_____ I am not pregnant, and I have no reason to suspect that I might be pregnant.

_____ I am not currently taking antibiotics.

_____ I understand the potential risks and complications and choose to proceed after careful consideration of the possibility of both known and unknown risks, complications, limitations and alternatives.

Please list any/all medical diagnoses you have been advised of by any treating medical personnel:
_____
_____
_____

Please list all medications and over-the-counter supplements you are currently taking:
_____
_____
_____

Please list all medical treatments you are presently receiving or have received in the last 3 months:
_____
_____

[SIGNATURE PAGE TO FOLLOW]

Of my own free will, I am requesting and providing my informed consent to undergo SkinSheek LIFT Treatment(s). I understand that this is an elective procedure, performed solely for cosmetic purposes, and is not critical to my health. I have asked any questions I had, and I have received answers to all my questions. I assume all risks as solely my own and hereby release Kathleen Cauthen and Skinology, LLC from any liability for any injury or damage whatsoever whether foreseen, now and forever. I acknowledge that I cannot sue or make a claim against Kathleen Cauthen and/or Skinology, LLC for any reason connected to this treatment. This consent and release is in effect for the above and all future SkinSheek LIFT Treatments I choose to have.

_____ _____

Client Signature Date

_____

Client Printed Name

_____ _____

Esthetician Date

SkinSheek LIFT Treatment Consultation Record:

As every Client is different, the clinical factors listed below are intended to assist in forecasting your clinical response to the SkinSheek LIFT Treatment. Please score each clinical factor listed below. Upon examination of your responses, your options for achieving optimal results with be discussed:

Age:	<35 y/o	35-49 y/o	50-64 y/o	65+ y/o
Smoking History:	Never	Ex-smoker	Light Smoker	Heavy Smoker
Sunscreen Use:	Never	Occasionally	Always	
Health:	No Health Issues	Minor Health Issues	Major Health Issues	Chronic Health Issues

Check the appropriate box

Upper Face	None	Mild	Moderate	Severe
Skin Laxity: excess skin or hooding on the eyelid or eyelid droopiness				
Volume: Presence of fat deposits under eyes or Intra-orbital puffiness				
Skin Quality: Fine lines, crepiness, wrinkling, and/or poor elasticity				
Lower Face and Neck				
Skin Laxity: excess or drooping skin at jowls or on neck				
Volume: Presence of fat deposits in lower face, loss of jaw detention, and/or excess sub-Q fat				
Skin Quality: Fine lines, crepiness, wrinkling, and/or poor elasticity				

What are your treatment goals?

_____
_____
_____

Additional information you believe may be relevant to the LIFT treatment:

_____
_____
_____

THIS SECTION FOR PROFESSIONAL USE ONLY

ACTION	COMPLETED	DATE ……
Pre-treatment photos taken		
Procedure reviewed with Client		
Client questions answered		
Informed Consent initialed and signed		
Photo consent initialed		
Previous treatment reviewed		
What to expect information provided		
Follow-up appointment scheduled		

Treatment Date: _____

Treatment Notes:

_____
_____
_____
_____
_____
_____
_____
_____

_____ _____

Client Signature Date

_____ _____

Esthetician Signature