Aesthetic Patient Intake & Contraindication Screening

GENERALIZED MED SPA & AESTHETIC PRACTICE TEMPLATE

Patient Name _____

Date of Birth _____

Date _____

Patient Name _____

DOB _____

Phone / Email _____

Primary Concern / Treatment Area _____

Current medications / supplements _____

Allergies _____

Prior aesthetic procedures / complications _____

Screen for relevant contraindications / precautions

- ■ Pregnant / breastfeeding
- ■ History of keloids / poor healing
- ■ Autoimmune / immune-suppressing condition
- ■ Recent isotretinoin use
- ■ Implanted electrical device
- ■ Prior filler in treatment area
- ■ Active infection / open wound
- ■ Bleeding disorder / anticoagulant use
- ■ Photosensitizing medication
- ■ History of cold sores / HSV
- ■ Recent surgery / procedure
- ■ Other condition requiring clinician review

Additional details / clinician review _____

Skin type / examination findings _____

Treatment clearance / modifications _____

Patient Signature: _____ **Date:** _____

Provider/Witness: _____ **Date:** _____

General Aesthetic Treatment Informed Consent

GENERALIZED MED SPA & AESTHETIC PRACTICE TEMPLATE

Patient Name _____

Date of Birth _____

Date _____

I voluntarily request an aesthetic evaluation and treatment. I understand that aesthetic outcomes vary and that no specific result, duration, symmetry, or degree of improvement can be guaranteed.

Potential risks vary by treatment and may include pain, tenderness, redness, swelling, bruising, bleeding, infection, pigment change, scarring, allergic or inflammatory reaction, asymmetry, unsatisfactory cosmetic result, need for additional treatment, and other known or unforeseen complications.

I have had an opportunity to discuss the proposed treatment, expected benefits, material risks, alternatives including no treatment, anticipated recovery, aftercare, and questions with the treating professional.

Proposed treatment / device / product _____

Treatment area(s) _____

Alternatives / special risks discussed _____

Patient Signature: _____ **Date:** _____

Provider/Witness: _____ **Date:** _____

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Laser / Light-Based Treatment Consent

GENERALIZED MED SPA & AESTHETIC PRACTICE TEMPLATE

Patient Name _____

Date of Birth _____

Date _____

I consent to treatment using the laser, IPL, or other light-based device identified below. I understand that the indication, wavelength/technology, settings, and treatment plan should be selected by appropriately qualified personnel under applicable law.

- ■ Temporary redness / swelling
- ■ Blistering / crusting
- ■ Burn / thermal injury
- ■ Hyperpigmentation
- ■ Hypopigmentation
- ■ Scarring / textural change
- ■ Eye injury if protective measures are not followed
- ■ Incomplete response / recurrence
- ■ Hair stimulation or paradoxical response where applicable
- ■ Need for multiple treatments

I agree to disclose tanning, sun exposure, new medications, skin products, pregnancy status, infection, or other changes before treatment and to follow eye-protection and aftercare instructions.

Device / treatment _____

Indication _____

Area _____

Pre-treatment instructions reviewed _____

Post-treatment instructions reviewed _____

Patient Signature: _____ **Date:** _____

Provider/Witness: _____ **Date:** _____

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Laser Hair Reduction Consent

GENERALIZED MED SPA & AESTHETIC PRACTICE TEMPLATE

Patient Name _____

Date of Birth _____

Date _____

I understand laser/light hair reduction generally requires a series of treatments and may produce reduction rather than permanent elimination of all hair. Response varies with hair color, skin type, hormones, treatment interval, and other factors.

- ■ Redness / perifollicular swelling
- ■ Pigment change
- ■ Incomplete reduction / regrowth
- ■ Eye injury without proper protection
- ■ Burn / blister
- ■ Scarring
- ■ Paradoxical hair stimulation

Treatment area(s) _____

Device / modality _____

Sun/tanning history reviewed _____

Medications reviewed _____

Patient Signature: _____ **Date:** _____

Provider/Witness: _____ **Date:** _____

Laser Tattoo Removal Consent

GENERALIZED MED SPA & AESTHETIC PRACTICE TEMPLATE

Patient Name _____

Date of Birth _____

Date _____

I understand tattoo removal commonly requires multiple sessions and complete removal cannot be guaranteed. Certain pigments may respond poorly, darken, change color, or leave residual pigment or 'ghosting.'

- ■ Pain / swelling / blistering
- ■ Bleeding / crusting
- ■ Infection
- ■ Scarring / texture change
- ■ Hyper- or hypopigmentation
- ■ Incomplete removal
- ■ Pigment darkening / color shift
- ■ Allergic or inflammatory reaction

Tattoo location / colors _____

Device / wavelength _____

Estimated treatment series discussed _____

Aftercare reviewed _____

Patient Signature: _____ **Date:** _____

Provider/Witness: _____ **Date:** _____

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Neuromodulator Injection Consent

GENERALIZED MED SPA & AESTHETIC PRACTICE TEMPLATE

Patient Name _____

Date of Birth _____

Date _____

I consent to injection of the neuromodulator identified below for the indication discussed with my clinician. I understand results are temporary and individual response varies.

- ■ Pain / bruising / swelling
- ■ Asymmetry / undesired cosmetic result
- ■ Dry eye / tearing
- ■ Difficulty swallowing / speaking / breathing (rare but serious)
- ■ Need for additional or corrective treatment
- ■ Headache
- ■ Eyelid or brow droop
- ■ Weakness of nearby muscles
- ■ Allergic reaction

Product _____

Treatment area(s) _____

Units / dose documented in clinical record _____

On-label / off-label use discussed where applicable _____

Patient Signature: _____ **Date:** _____

Provider/Witness: _____ **Date:** _____

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Dermal Filler Injection Consent

GENERALIZED MED SPA & AESTHETIC PRACTICE TEMPLATE

Patient Name _____

Date of Birth _____

Date _____

I consent to injection of the dermal filler identified below. I understand fillers can cause common injection-site effects and rare but serious complications.

- ■ Pain / tenderness / swelling
- ■ Bruising / bleeding
- ■ Lumps / nodules / irregularity
- ■ Asymmetry / migration
- ■ Infection
- ■ Delayed inflammatory reaction
- ■ Herpes reactivation
- ■ Skin injury / necrosis from vascular occlusion
- ■ Visual impairment / blindness (rare)
- ■ Stroke or neurologic injury (rare)
- ■ Need for dissolution or other corrective treatment

I understand that symptoms suggesting vascular compromise or visual/neurologic change require immediate evaluation.

Product / lot documented in clinical record _____

Treatment area(s) _____

Emergency plan discussed _____

Prior filler / implant history _____

Patient Signature: _____ **Date:** _____

Provider/Witness: _____ **Date:** _____

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Hyaluronidase / Filler Dissolution Consent

GENERALIZED MED SPA & AESTHETIC PRACTICE TEMPLATE

Patient Name _____

Date of Birth _____

Date _____

I consent to hyaluronidase treatment when clinically appropriate to dissolve hyaluronic-acid filler. I understand the degree and location of dissolution can be unpredictable and repeat treatment may be required.

- ■ Pain / redness / swelling
- ■ Bruising
- ■ Allergic reaction
- ■ Over-correction / loss of desired filler effect
- ■ Incomplete dissolution
- ■ Need for repeat or additional treatment

Indication _____

Treatment area _____

Allergy history reviewed _____

Emergency use vs elective correction _____

Patient Signature: _____ **Date:** _____

Provider/Witness: _____ **Date:** _____

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Microneedling / RF Microneedling Consent

GENERALIZED MED SPA & AESTHETIC PRACTICE TEMPLATE

Patient Name _____

Date of Birth _____

Date _____

I consent to microneedling and, if selected, radiofrequency energy delivered through microneedles. I understand results vary and a series of treatments may be recommended.

- ■ Redness / swelling
- ■ Pain / tenderness
- ■ Acne / HSV flare
- ■ Scarring / texture change
- ■ Prolonged erythema
- ■ Pinpoint bleeding / crusting
- ■ Infection
- ■ Pigment change
- ■ Burn / thermal injury with RF
- ■ Unsatisfactory result

Treatment type / device _____

Area(s) _____

Topical products used _____

Aftercare reviewed _____

Patient Signature: _____ **Date:** _____

Provider/Witness: _____ **Date:** _____

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Chemical Peel Consent

GENERALIZED MED SPA & AESTHETIC PRACTICE TEMPLATE

Patient Name _____

Date of Birth _____

Date _____

I consent to application of the chemical peeling agent identified below. Depth and response depend on the agent, concentration, skin characteristics, preparation, and treatment technique.

- ■ Burning / stinging
- ■ Redness / swelling
- ■ Peeling / crusting
- ■ Infection
- ■ HSV reactivation
- ■ Hyperpigmentation
- ■ Hypopigmentation
- ■ Scarring
- ■ Prolonged sensitivity / redness
- ■ Incomplete or uneven result

Peel / concentration _____

Treatment area _____

Pre-peel preparation _____

Post-peel care _____

Patient Signature: _____ **Date:** _____

Provider/Witness: _____ **Date:** _____

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IPL / Photofacial Consent

GENERALIZED MED SPA & AESTHETIC PRACTICE TEMPLATE

Patient Name _____

Date of Birth _____

Date _____

I consent to intense pulsed light treatment for the indication discussed. I understand IPL is light-based treatment and is not appropriate for every skin type, medication, or condition.

- ■ Redness / swelling
- ■ Burn / blister
- ■ Crusting
- ■ Pigment change
- ■ Scarring
- ■ Eye injury without protection
- ■ Temporary darkening of pigmented lesions
- ■ Incomplete response / recurrence

Indication _____

Area(s) _____

Skin assessment / sun exposure reviewed _____

Device _____

Patient Signature: _____ **Date:** _____

Provider/Witness: _____ **Date:** _____

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Body Contouring / Energy-Based Treatment Consent

GENERALIZED MED SPA & AESTHETIC PRACTICE TEMPLATE

Patient Name _____

Date of Birth _____

Date _____

I consent to the non-surgical body contouring or energy-based treatment identified below. I understand results vary and treatment is not a substitute for weight-loss treatment or surgery.

- ■ Pain / tenderness
- ■ Bruising
- ■ Burn / thermal injury
- ■ Temporary muscle soreness
- ■ Need for additional treatment
- ■ Redness / swelling
- ■ Numbness / altered sensation
- ■ Contour irregularity / asymmetry
- ■ Unexpected tissue response

Device / modality _____

Treatment area(s) _____

Expected treatment series _____

Contraindications reviewed _____

Patient Signature: _____ **Date:** _____

Provider/Witness: _____ **Date:** _____

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PRP / PRF Aesthetic Procedure Consent

GENERALIZED MED SPA & AESTHETIC PRACTICE TEMPLATE

Patient Name _____

Date of Birth _____

Date _____

I consent to collection and preparation of my own blood for platelet-rich plasma (PRP) or platelet-rich fibrin (PRF) treatment as described by my clinician.

- ■ Blood draw discomfort / bruising
- ■ Bleeding
- ■ Infection
- ■ Pain / swelling
- ■ Inflammatory reaction
- ■ Nerve or tissue injury
- ■ Unsatisfactory or variable cosmetic response
- ■ Need for repeat treatment

Procedure / treatment area _____

Preparation system _____

Injection / topical use _____

Alternatives discussed _____

Patient Signature: _____ **Date:** _____

Provider/Witness: _____ **Date:** _____

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Aesthetic Photography & Image Authorization

GENERALIZED MED SPA & AESTHETIC PRACTICE TEMPLATE

Patient Name _____

Date of Birth _____

Date _____

Clinical photographs may be useful for documentation, treatment planning, comparison, and quality assurance. Clinical documentation consent should be distinguished from optional marketing/publication authorization.

- ■ I consent to clinical photographs becoming part of my medical record.
- ■ I authorize de-identified educational use as separately described by the practice.
- ■ I authorize marketing/social-media use only under the practice's separate, revocable authorization terms.
- ■ I do NOT authorize marketing/publication use.

Specific permitted uses / limitations _____

Expiration or revocation terms if applicable _____

Patient Signature: _____ **Date:** _____

Provider/Witness: _____ **Date:** _____

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Post-Treatment Instructions & Adverse Event Acknowledgment

GENERALIZED MED SPA & AESTHETIC PRACTICE TEMPLATE

Patient Name _____

Date of Birth _____

Date _____

I received procedure-specific aftercare instructions and understand whom to contact for questions or unexpected symptoms.

I understand that severe pain, rapidly worsening swelling, skin discoloration suggestive of compromised blood flow, visual changes, neurologic symptoms, breathing difficulty, severe allergic symptoms, fever, spreading infection, or other concerning symptoms may require urgent or emergency evaluation.

Procedure _____

Aftercare provided verbally / written / electronic _____

Practice contact instructions _____

Specific warning signs discussed _____

Patient Signature: _____ **Date:** _____

Provider/Witness: _____ **Date:** _____

Treatment Refusal / Procedure Cancellation Acknowledgment

GENERALIZED MED SPA & AESTHETIC PRACTICE TEMPLATE

Patient Name _____

Date of Birth _____

Date _____

I acknowledge that the proposed aesthetic treatment was deferred, declined, or cancelled for the reason documented below. I understand the potential consequences of proceeding elsewhere or disregarding safety recommendations.

Proposed treatment _____

Reason deferred / declined / cancelled _____

Alternatives / follow-up discussed _____

Patient comments _____

Patient Signature: _____ **Date:** _____

Provider/Witness: _____ **Date:** _____

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