
**Hydra Facial Consent Form**
Devices include HydraFacial MD Prototypes

I _____(Patient Name) hereby authorize _____ (Medical Provider Name) and/or such assistants may be selected to perform the Hydra Facial procedure. The medical provider obtained my medical history and found me eligible for treatment.

**Select treatment regimen(s)**

_____ HydraFacial _____ Microdermabrasion _____ Wet Diamond

_____ Blue/Red Light Therapy _____ Lymphatic/Massage Therapy _____ Other modalities

**SECTION 1: MEDICAL INFORMATION** (Note: Please circle YES or NO if any of the following applies to you)

Absolute Contraindications
Yes___No___ Accutane or other similar medication
Yes___No___ Autoimmune disease, HIV, lupus, hepatitis, scleroderma
Yes___No___ Active infection in the treatment area
Yes___No___ Melanoma or lesions suspected of malignancy
Yes___No___ Active Sunburn
Yes___No___ Pregnancy
Yes___No___ Breastfeeding may increase skin sensitivity and likelihood of PIH
Yes___No___ Epilepsy contraindicated for LED light therapy

Relative Contraindications
Yes___No___ Anticoagulants therapy (use lower settings)
Yes___No___ Very thin skin
Yes___No___ Other Aesthetic Treatments: Botox: wait 5-7 days; Fillers: wait 7-10 days; Peels: wait 30 days
Yes___No___ Laser Treatments: wait until lesions heal & swelling & redness is resolved

Other Concerns
Yes___No___ Keloids: avoid direct contact
Yes___No___ Rosacea, telangiectasia (lower vacuum)
Yes___No___ Unrealistic expectations

NOTE: If you answered YES to any of the above questions, please explain:
_____

Please list any known allergies:_____



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Med Spa Services Supervised by Medical Director Dr. Abdullah Farooque MD

**SECTION 2: CLIENT CONSENT FORM**

- ☐ I acknowledge that my skin might experience temporary irritation, tightness, or redness, which usually dissipates within 72 hours depending on skin sensitivity.
- ☐ I acknowledge that if I fail to use a minimal **sunscreen (SPF 30)** and follow the directions for use, I am more susceptible to sunburn, sun damage & hyperpigmentation. I should avoid excessive sun exposure, esp. 10am-2pm.
- ☐ I have disclosed my history of allergies above and I acknowledge that I may experience an allergic reaction.
- ☐ I hereby agree to have the treatment performed and agree to follow all pre-and post-treatment instructions.
- ☐ I acknowledge that I should avoid use of aggressive exfoliation, waxing, and products containing acids that are not part of the recommended take-home regimen in the treated areas for minimum 2 weeks pre and post-treatment.
- ☐ I acknowledge that I should avoid use of Retin-A type products for a period of time recommended by my physician and /or skincare practitioner per and post the treatment.

**MEDICAL HISTORY:** I have informed the medical provider of all my known allergies and all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies, antiplatelet or anticoagulation medications. I have been advised about which of these medications I should avoid taking on the days surrounding the procedure. I understand that the medical provider will rely on my documented medical history, as well as other information obtained from me in determining whether to perform this procedure. I have provided and agree to continue to provide accurate/complete info about my medical history and conditions. At this time, I am not pregnant/nursing and do not have any contraindication to this procedure.

**FOLLOW-UP:** I agree to follow up with the medical provider at the recommended intervals at the Valley Health Clinic office location)s) and to contact the clinic if there is any change in my condition, medical history or any problem I may experience. I agree to call the office immediately and/or use the after hours number _____ should any unusual side effects occur. I understand that in case of a medical emergency, I should call 911 or go to an emergency medical facility.

**CONSENT FOR TREATMENT:** I _____(Patient NAME) herby voluntarily request _____(Medical Provider/Injector NAME) who is a licensed clinician to provide elective, aesthetic treatment. The procedure has been explained to me and my questions regarding such treatment, its alternative, its complications, and its risk have been answered. The information provided is clear and I understand the risks/complications of the treatment. My questions have been fully answered and I have read this document to understand its contents. I understand that there are no guarantees, all sales are final, and payment is due at time of treatment. I understand that I will continue to age and may need additional treatments/products in the future. I understand that aesthetic treatments are not going to take care of all my aging skin needs. I hereby give my unrestricted informed consent for treatment of designated aesthetic procedure/product. I also understand that this consent is valid for future treatments unless the policies of the office or the known risks for the procedure/product change. By signing this form I acknowledge that guarantees as to the final results of my treatment have not been made. THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING.

**Initials: _____** I release the device manufacturer, medical provider/injector(s), and staff of Valley Health Clinic LLC and Revive Aesthetics LLC from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products.

**Initials: _____** I authorize before, during and after the procedure(s) the taking of photographs to be part of my patient profile that may be used for educational, promotion or advertising purposes without disclosing my identity. I also release Valley Health Clinic LLC and its associated staff including Revive Aesthetics LLC from any liability in connection with the use of such photographs and/or videos. My name will not be used to identify these photographs without my written approval.

| _____ | _____ | _____ |
|---|---|---|
| Patient Name Printed | Patient Name Signed | Date |
| _____ | _____ | _____ |
| Medical Provider Name Printed | Medical Provider Name Signed | Date |



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