# Ease Electrolysis, LLC Consent Form

Patient Name:_____

Treatment Areas:_____

I duly authorize the professional associates of Ease Electrolysis, LLC to perform electrolysis on me.

I understand that the electrologist inserts a very fine sterilized needle alongside the hair in the hair follicle. A tiny amount of electrical current is then applied through this needle to the hair root permanently ending further hair growth when the hair is in the active or anogen stage of growth.

I have been specifically advised that this office has implemented infection control procedures, which include:

1. Single use sterilized disposable needles.

2. A “sharps” disposal unit.

3. An autoclave sterilizer as well as an ultrasonic cleanser prior to sterilization for tweezers.

__I agree to a 24 hour cancellation fee of a 15 minute service. Emergencies excluded.

__I have read the pre & post treatment care card.

__I confirm that I have not taken Accutane for at least one year.

__I certify that I have been fully informed of the nature and purpose of the procedure, expected outcome and possible complications and I understand that no guarantee can be given as to the final result obtained.

Many factors (especially the previous methods of hair removal) determine the number and the length of treatments required. The closer you adhere to your treatment schedule, the more effective your treatment will be. Usually this takes 1.5 to 2 years before all hair is gone permanently in the treated area. I understand compliance with treatment guidelines is crucial for optimum results. I have read and understood all information presented to me before signing this consent.

In consideration for Ease Electrolysis, LLC performing this procedure, I agree that I will assume the risk and full responsibility for any and all injuries, losses, or damages, which might occur to me while I am undergoing this procedure or side effects I may experience after the procedure is performed. To the maximum extent allowed by law, I agree to waive and release any and all present and future claims, suits or related causes of action against Ease Electrolysis, LLC, its owners, officers, employees, or agents for negligence, injury, loss, death, costs or other injuries or damages to me as a result of this procedure.

Printed name:_____

Signature:_____

Date:_____

# Patient Profile

Name:_____DOB:_____Age:_____
Address:_____
City:_____State:_____Zip:_____
Preferred Contact Phone Number:_____
Email Address:_____
Emergency Contact (Name and number):_____
How did you hear about Ease Electrolysis, LLC?_____
What type of work do you do?_____

- Do you have a communicable disease that we should know about (Ex.: HIV, Hepatitis)?_____
- Do you have any metal in your body?_____
- Are you pregnant or lactating? Yes____No____ Do you want to become pregnant? Yes____No____
- Last menstrual period?_____
- Do you wear contact lenses? Yes____No____ (Remove contacts if eyes are sensitive.)
- Do you currently use or receive depilatories or waxing? Yes____No____ (Discontinue use five days pre-and post-treatment.)
- Are you in the habit of going to tanning booths? Yes____No____
  (If within past 14 days, decline treatment; we recommend this practice is discontinued altogether.)
- Are you applying any topical medications at this time? Yes____No____ Which one(s)?_____
- (High percentages of certain ingredients may increase sensitivity)
- Are you currently using any topical Retinoid prescriptions
  (Trentinoin/Retin-A"/Renova"/Differin"/Tazorac"/Avage"/EpiDuo™/Ziana")? Yes____No____
  What strength?_____ For how long?_____
  (Discontinue use five days before and after treatment. Consult your physician before discontinuing use of any prescription.)
- Are you currently using "Accutane"? Yes____No____ For how long?_____

***Those who are currently taking Accutane" should be directed to their dispensing physician.***

- Have you had a chemical peel or any type of procedure within the last 14 days? Yes____No____
- Do you have regular collagen, Botox' or other dermal filler injections? Yes____No____
  (Peels should precede or follow injections by two days to prevent movement of the filler or stinging at the injection site.)
- Have you recently had facial surgery? Yes____No____ Describe:_____
- Have you recently had laser resurfacing? Yes____No____ When?_____ What type?_____
- Do you smoke or use tobacco? Yes____No____
- Do you develop cold sores/fever bilsters? Yes____No____
- Are you allergic/sensitive to? (Check all that apply)
  Milk____Apples____Citrus____Grapes____Aloe vera____Aspirin____Perfumes____Latex____Hydroquinone____Mushrooms____
  If any other allergies, what?_____
- Have you ever used any other products that caused a bad reaction? Yes____No____
- Are you taking any medication at this time? (Antibiotics may increase sensitivity)_____
- What is your hereditary background?_____
- Skin tone:_____
- Do you consider your skin: Sensitive____ Resilient____ Unsure____ ?
- Please describe your skin:_____

**Client Acknowledgement and Agreement: I certify that the information given is true to the best of my knowledge and certify that I will notify the office immediately if any changes occur in my medical history/heatlh status. I hereby release and discharge Ease Electrolysis, LLC and its employees and agents from any and all claims that I have or may have in the future in connection with my treatment relating to any and all procedures performed by Ease Electrolysis, LLC, regardless of the results.**

**Patient Signature:**_____**Date:**_____